

Determinants of Attitudes Toward Sexuality in Women With Gynecological Cancer: A Cross-Sectional Study

Kerime Derya Beydağ

kdergabeydag@gmail.com

Yalova University

Elif BALKAN KURU

Yalova University

Research Article

Keywords: gynecologic cancer, sexuality, attitude, scale

Posted Date: October 6th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-10843202/v1>

License: © ⓘ This work is licensed under a Creative Commons Attribution 4.0 International License.

[Read Full License](#)

Additional Declarations: No competing interests reported.

Abstract

Objective

To identify the factors influencing attitudes toward sexuality in women diagnosed with gynecological cancer.

Method

This descriptive, cross-sectional study was conducted with 212 patients who presented to the gynecologic oncology department of a private hospital in Istanbul between March and August 2025. Data were collected using a demographic questionnaire and the Attitudes Toward Sexuality in Gynecologic Cancers Scale (ATSGC).

Results

The **women's** total scale score was 46.41 ± 18.17 ; the "attitude toward sexual desire" subscale score was 14.66 ± 4.34 points, and the "attitude toward sexual life" subscale score was 31.75 ± 14.84 . A significant positive correlation was found between the participants' age and their ATSGC total score. It was determined that participants with advanced-stage cancer and those who had not received education regarding the impact of gynecological cancers on sexual life had more negative attitudes toward gynecological cancers ($p < .05$). As women's educational level increases, their negative attitudes toward sexual life decrease; however, as age increases, negative attitudes increase. It was determined that whether participants had received education regarding sexuality in the context of cancer was the independent variable that predicted attitude scores most strongly and in a positive direction.

Conclusion

It is recommended that sexual health be incorporated as a routine and comprehensive part of the care process for women diagnosed with gynecological cancer. It is particularly important to prioritize the assessment of women who are older, have a lower level of education, have been diagnosed with advanced-stage cancer, and have not received education on sexual health.

1. Introduction

Although cancer has a similarly devastating impact across all types in terms of threatening life and bringing about challenging experiences, certain types of cancer, by their very nature, lead to distinct, type-specific outcomes.¹ In this context, while a general cancer diagnosis has a significant impact on the patient, the meaning of a gynecologic cancer diagnosis for women and the psychosocial impact it creates can be much deeper. It directly shapes relationships with partners, family, and the social

environment, in addition to factors such as sexual identity, the definition of gender roles, sexual harmony, and emotional fulfillment. It is also expressed in conjunction with numerous sociocultural factors, including thoughts, desires, beliefs, values, behaviors, and roles.²

Despite advances in the diagnosis and treatment of gynecological cancers, women—particularly those undergoing treatment for gynecological cancers—experience treatment-related side effects (nausea, vomiting, etc.), physical (weakness, fatigue, etc.) and psychological (depression, anxiety, etc.) conditions, changes observed in the female genitalia (pain, dryness, loss of elasticity, etc.), and organ loss negatively affect sexuality, often resulting in the exclusion of sexuality from a woman's life.³

A review of the literature on women with gynecological cancer reveals that women who have been diagnosed with cancer and are undergoing treatment, as well as those who have undergone surgery due to a cancer diagnosis, often avoid sexual intercourse or cease sexual activity entirely for reasons such as a decrease in sexual desire, impaired self-esteem, pain during sexual intercourse, inability to experience pleasure, the fear that sexual intercourse will negatively affect the course of the disease, and the fear of harming their partner—a significant portion of these women avoid sexual intercourse or cease sexual activity entirely. Furthermore, studies have shown that women whose sexual health is negatively affected tend to avoid seeking information or solutions regarding the problem; consequently, they do not consult any healthcare professionals, conceal their issues, and view sexuality as shameful due to their illness.^{4–6}

Nurses play a key role in managing the sexual health issues of women undergoing gynecological cancer treatment. By actively addressing sexual health issues at every stage of patient care, nurses contribute to patients' physical, psychological, and social well-being. Nurses also play an educational role by correcting misconceptions about sexual health and helping patients understand the effects of cancer treatment on their sexual health.^{7,8}

The purpose of this study is to identify the factors influencing the attitudes toward sexuality among women diagnosed with gynecological cancer.

2. MATERIALS AND METHODS

2.1. Study Design

This is a cross-sectional, descriptive study.

2.2. Study Site and Time

The study was conducted in the gynecologic oncology unit of a private hospital on the European side of Istanbul between March 1 and August 1, 2025.

2.3. Study Participants

The study participants consisted of women diagnosed with gynecological cancer. The study population consisted of women who presented to the gynecologic oncology unit at the hospital where the study was conducted. The sample size was calculated using the G*Power 3.1.9.7 software. Multiple linear regression analysis was used to identify the factors influencing the attitudes toward sexuality among women diagnosed with gynecological cancer. The calculations considered a small-to-moderate effect size ($f^2=0.08$), a 95% confidence level ($\alpha = 0.05$), 95% power ($1 - \beta = 0.95$), and 10 independent variables. As a result of the power analysis, the minimum required sample size for the study was determined to be 212 participants. The sample included women aged 18–65 who had a sexual partner and agreed to participate in the study.

2.4. Data Collection

After providing explanatory information about the study to individuals who met the inclusion criteria, questionnaire forms were distributed to them. After the participants completed the questionnaires, the forms were collected, and any questions from participants were answered. After the purpose of the study was explained to the participants, written consent was obtained from all participants. It took approximately 10 minutes for each participant to complete the questionnaire.

2.5. Data Collection Tools

Data in the study were collected using the Informed Consent Form and the Attitudes Toward Sexuality in Gynecologic Cancers Scale.

Demographic Information Form

Developed by the researchers based on the literature, this form consists of a total of 11 questions designed to determine the participants' sociodemographic characteristics.^{9,10}

Attitude Scale Toward Sexuality in Gynecological Cancers (ATSGC): Developed by Utkulu (2024) to assess attitudes toward sexuality in gynecological cancers, this scale uses a 5-point Likert scale (Strongly Agree = 5, Agree = 4, Undecided = 3, Disagree = 2, Strongly Disagree = 1) and consists of a total of 15 questions. It has two distinct subscales: attitudes toward sexual life and attitudes toward sexual desire. Higher scores on the scale are interpreted as indicating more negative attitudes. In the scale's development study, the Cronbach's alpha reliability coefficient was found to be $\alpha = .97$.¹¹ In this study, the Cronbach's alpha reliability coefficient for the scale was found to be $\alpha = .97$.

2.6. Data Analysis

The data obtained in this study were analyzed using SPSS (v.26). The Kolmogorov-Smirnov test, along with measures of kurtosis and skewness, was used to determine normality of distribution. The Mann-Whitney U test and the Kruskal-Wallis test were used to compare the data, and the Spearman correlation test was used for correlation analysis. When interpreting the analysis results, a p-value of $< .05$ was considered statistically significant.

2.7 Ethical Statements

Prior to the study, an application was submitted to a Istanbul Okan University Ethics Committee, and ethical approval was obtained at the meeting held on February 5, 2025, under No. 185. The necessary permissions were obtained from the hospital where the study was to be conducted. The study was conducted in accordance with the ethical principles of the Declaration of Helsinki of the World Medical Association. Participation was voluntary, and all participants were informed about the purpose and procedures of the study before providing informed consent. Confidentiality and anonymity of the participants were ensured throughout the research process.

2.8 Limitations of the Study

The data obtained in the study are limited to the responses provided by the participants.

3. FINDINGS

The mean age of the participants in the study was determined to be 49.11 ± 8.74 . Forty-two percent of the participants had a diagnosis of endometrial cancer, 32% had ovarian cancer, and 19.8% had cervical cancer; the majority of participants (33.5%) had Stage II cancer. For 74.5% of the participants, cancer treatment has been ongoing for 1 to 5 years, and 78.8% are receiving chemotherapy. While 92.9% of the participants had a history of surgery due to their cancer diagnosis, it was found that 68.4% had not received any education regarding the effects of cancer on sexual life (Table 1).

A statistically significant positive correlation was found between the participants’ age and their ATSGC scores. It was found that the total scale scores of participants who were not employed were higher than those of employed women. It was also found that participants with an elementary or middle school education level had higher average scale scores. Similarly, the scale scores of participants with low income levels were statistically significantly higher than those of other income levels ($p<.05$). However, it was determined that the average scale score did not differ based on variables such as having living children, cancer type (breast, cervical, etc.), duration of treatment, whether the participant received chemotherapy, or whether the participant underwent surgery due to cancer ($p>.05$). A statistically significant difference in the average ATSGC scores was found based on cancer stage; accordingly, participants’ average scores increased as the cancer stage progressed (Stage I, Stage II, Stage III), while participants who did not know their cancer stage had the highest average score ($p<.05$). A statistically significant difference was found in scale scores between participants who had and had not received education regarding the impact of gynecological cancers on sexual life; participants who had not received education had higher scores, indicating that their attitudes toward gynecological cancers were more negative ($p < .05$) (Table 1).

Table 1. Findings on Participants’ Sociodemographic Characteristics and Cancer History

Characteristic		Min– Max	Mean ± SD		Test Value	p
Age		25– 65	49.11±8.74		r_s : .399	<.001**
Characteristic		n	%	Mean ± SD	Test Value	p
Marital status	Single	16	7.5	41.06 ± 10.30	Z: -1.238	.216
	Married	196	92.5	46.85±18.61		
Employment status	Employed	68	32.1	42.30 ± 16.19	Z: -2.321	.020*
	Not working	144	67.9	48.36±18.77		
Educational status	Elementary and middle school	77	36.3	59.36 ± 13.20	KW: 65.293	<.001**
	High School	83	39.2	41.39±16.02		
	College	52	24.5	35.26 ± 16.52		
Income level	Low	40	18.9	58.57 ± 13.38	KW: 35.972	<.001**
	Moderate	156	73.6	45.26 ± 17.73		
	High	16	7.5	27.25 ± 11.43		
Do you have children?	Yes	170	80.2	46.67 ± 18.52	Z: -.621	.535
	None	42	19.8	45.38±16.85		
Cancer diagnosis	Ovarian cancer	69	32.5	47.18 ± 16.73	KW: .189	.979
	Endometrial cancer	89	42.0	46.11 ± 19.97		
	Cervical cancer	42	19.8	45.71 ± 17.40		
	Other	12	5.7	46.75 ± 16.65		
How many years have you been	Less than 1 year	47	22.2	42.74 ± 12.73	KW: 2.867	.238

receiving treatment?	1–5 years	158	74.5	47.44 ± 19.48		
	More than 6 years	7	3.3	48 ± 17.33		
Chemotherapy status	Yes	167	78.8	47.50±19.33	Z: -1.942	.052
	No	45	21.2	42.40 ± 12.37		
Status of undergoing surgery due to cancer	Yes	197	92.9	46.82±18.45	Z: -1.263	.207
	No	15	7.1	41.06 ± 13.21		
Cancer stage	Don't know	33	15.6	58.33 ± 14.84	KW: 20.899	<.001**
	Stage I	50	23.6	40.26±16.02		
	Stage II	71	33.5	43.67 ± 19.62		
	Stage III and above	58	27.4	48.31 ± 16.63		
Status of receiving education regarding the impact of cancer on sexual life	Received	67	31.6	28.01±11.11	Z: -9.879	<.001**
	Did not take	145	68.4	54.92±14.03		

KW: Kruskal-Wallis test, Z: Mann-Whitney U test, *: **, rs:

The mean scores obtained by the participants on the ATSGC are presented in Table 2. The total scale score was determined to be 46.41±18.17 out of 75 points. Participants scored 14.66 ± 4.34 on the “Attitudes Toward Sexual Desire” subscale and 31.75 ± 14.84 on the “Attitudes Toward Sexual Life” subscale.

Table 2. Findings Regarding the Attitudes Toward Sexuality Scale in Gynecologic Cancers

Scale Subscale	Minimum–maximum	Mean ± SD
Attitudes Toward Sexual Desire	4–20	14.66 ± 4.34
Attitudes Toward Sexual Life	11–55	31.75±14.84
Total Scale Score	15–75	46.41±18.17

A hierarchical multiple linear regression analysis was conducted to determine the sociodemographic factors influencing participants’ attitudes toward sexuality in the context of gynecological cancers. In the first step (Model 1), sociodemographic characteristics were included in the model as control variables. In

the second step (Model 2), education status regarding the impact of cancer on sexuality was added to the model. Model 1 was found to be statistically significant ($F(4,207) = 28.58, p < .001$). Sociodemographic variables explain 35.6% of the variance in ATSGC scores ($R^2 = .356$). Among the variables in Model 1, educational status ($\beta = -.446, t = -6.90, p < .001$) and age ($\beta = .213, t = 3.38, p = .001$) significantly predicted attitude scores, whereas the employment status and income level variables were found not to make a significant contribution to the model ($p > .05$) (Table 3).

Model 2, created by adding the variable “whether or not participants received education regarding sexuality” to Model 1, was found to be significant ($F(5, 206) = 51.66, p < .001$), and the explained variance increased to 55.6% ($R^2 = .556$). Including the variable “status of receiving education regarding the impact of cancer on sexuality” in the model resulted in a significant 20% increase in the explained variance of attitude scores after controlling for the effects of sociodemographic variables ($\Delta R^2 = .200, \Delta F(1,206) = 93.12, p < .001$) (Table 3).

Upon examining Model 2, it was found that participants’ status regarding receiving education on sexuality in the context of cancer was the independent variable that predicted attitude scores most strongly and in a positive direction ($\beta = .517, t = 9.65, p < .001$). Furthermore, it was observed that the variables educational status ($\beta = -.248, t = -4.08, p < .001$) and age ($\beta = .128, t = 2.49, p = .014$) retained their significant predictive roles. However, the variables of employment status and income level remained statistically insignificant in the final model ($p > .05$) (Table 3).

Table 3. Hierarchical Multiple Linear Regression Analysis of Predictors of the ATSGC Total Score

Model / Variable	B	S.E	β	t	p	VIF
Model 1						
(Constant)	61.22	5.82	-	10.52	< .001	-
Age	0.44	0.13	.213	3.38	.001	1.19
Employment Status	1.35	2.51	.035	0.54	.591	1.10
Educational Status	-10.42	1.51	-.446	-6.90	< .001	1.67
Income Level	-2.85	2.12	-.087	-1.34	.181	1.48
Model 2						
(Constant)	29.41	5.21	-	5.65	< .001	-
Age	0.27	0.11	.128	2.49	.014	1.22
Employment Status	0.86	1.89	.022	0.46	.650	1.10
Educational Status	-5.79	1.42	-.248	-4.08	< .001	1.71
Income Level	-1.28	1.86	-.039	-0.69	.492	1.48
Status of receiving education regarding the impact of cancer on sexuality	19.95	2.07	.517	9.65	< .001	1.33

For Model 1, $R^2 = .356$, $Adjusted\ R^2 = .344$, $F(4, 207) = 28.58$, $p < .001$.

For Model 2, $R^2 = .556$, $Adjusted\ R^2 = .545$, $F(5, 206) = 51.66$, $p < .001$, $\Delta R^2 = .200$, $\Delta F(1, 206) = 93.12$, $p < .001$.

DISCUSSION

Gynecological cancers and the treatment methods used for these cancers are complex processes that profoundly affect women's physical, psychological, and social lives. 68.4% of the patients participating in the study reported that they had not received any education or information regarding the effects of cancer on their sexual lives. Radical surgery (removal of the uterus and ovaries) performed in the treatment of gynecological cancers, loss of vaginal tissue, and early menopause resulting from chemotherapy lead to vaginal dryness, painful sexual intercourse (dyspareunia), loss of body image, and a significant decrease in sexual desire.^{12,13} A review of similar studies in the literature also reveals that sexual health is frequently neglected in care processes. The literature reports that between 60% and 75% of patients do not discuss their sexual lives with any healthcare professional or receive information on the subject during treatment.^{14,15} Studies conducted in Turkey also emphasize that patients are left to cope with their sexual problems alone due to cultural factors, taboos, clinical workload, and healthcare

personnel downplaying their counseling roles in this area.^{16,17} The 68.4% rate of patients not receiving counseling found in our study strongly supports this systemic deficiency in the literature and the fact that patients' information needs are not being met.

When the relationship between patients' sociodemographic characteristics and scale scores was examined in our study, it was found that increasing age, unemployment, a low level of education (elementary–middle school), and a perception of low income were associated with more negative attitudes toward gynecological cancers ($p < 0.05$). As women age, factors such as changes in body image, menopausal symptoms, and cultural reluctance to discuss sexuality can make it more difficult for patients to adapt to their illness and sexual life. The literature also indicates that older women and those with lower education and income levels are more likely to view sexual health issues following a cancer diagnosis as “fate” or “a taboo subject that should not be discussed,” and that this situation negatively affects their attitude and adjustment scores.^{18,19} In addition, the fact that working women with economic independence more actively use channels for accessing information and have higher levels of health literacy may have enabled patients in this group to develop a more positive and adaptive attitude toward the cancer process and their sexual lives.¹⁷

When evaluated in terms of clinical variables, it was found that factors such as whether patients had living children, cancer type (ovarian, cervical, etc.), duration of treatment, and whether they received chemotherapy or underwent surgery did not statistically significantly alter the mean scale scores ($p > 0.05$). A review of the literature highlights that, rather than the type of gynecological cancer itself, the general psychosexual effects caused by treatment processes targeting the female reproductive organs (organ loss, vaginal deformity, hormone deficiency) impose a similar burden across all patient groups.^{13,20} Furthermore, the fact that surgery and chemotherapy cause systemic and local effects in nearly all gynecologic cancer patients, regardless of the specific organ involved, may explain why clinical variables do not produce a significant difference in attitudes.¹²

In contrast, it was found that as the stage of cancer progresses, patients' scale scores increase—meaning their attitudes become more negative—and that patients who are unaware of their cancer stage have the most negative attitude scores ($p < 0.05$). In advanced-stage cancers, the increasing burden of symptoms, more radical treatment approaches, and the fear of recurrence significantly impair patients' overall quality of life and psychosocial adjustment. The highest negative attitude score among patients who were unaware of their cancer stage can be explained by the concept of “uncertainty in illness,” which is frequently emphasized in the literature. Patients with insufficient information about their diagnosis or the course of their disease exhibit higher levels of anxiety, helplessness, and negative attitudes toward the process due to this uncertainty. ^{15,21}

Another important finding of our study is that patients who received education regarding the impact of gynecological cancers on sexual life had significantly lower scale scores; in other words, those who received education had positive/adaptive attitudes, while those who did not receive education had markedly more negative attitudes ($p < 0.05$). Structured patient education and sexual counseling services

help patients normalize the physiological and psychological changes resulting from treatment, develop coping mechanisms, and maintain their relationships with their partners.^{14,22} The literature has shown that education provided using evidence-based counseling models, in particular, increases patients' knowledge and significantly reduces their negative attitudes and anxiety. ^{16,23} This finding from our study directly demonstrates the critical role that patient education and counseling play in oncology care.

The mean total score of the patients participating in our study on the Attitude Scale Toward the Impact of Gynecological Cancers on Sexual Life (ATSGC) was determined to be 46.41 ± 18.17 out of 75 points. Since a higher score on the scale indicates that patients' attitudes toward the impact of gynecological cancer on their sexual life are more negative, this result reveals that the women in our sample exhibit a negative attitude toward their sexual life—above the moderate level—and significant psychosexual adjustment difficulties during the course of their illness and treatment.

When the scale's subscales were examined, it was determined that patients scored 14.66 ± 4.34 on the "Attitudes Toward Sexual Desire" subscale and 31.75 ± 14.84 on the "Attitudes Toward Sexual Life" subscale. These scores indicate that sexual aversion and the process of adapting to general sexual life place a significant negative burden on patients. A review of the literature reveals that between 50% and 90% of patients diagnosed with gynecological cancer experience severe sexual dysfunction and negative attitudes during and after treatment.^{12,13} The decrease in sexual desire and the resulting negative attitudes are directly related to physiological processes such as surgical menopause resulting from radical surgery, the sudden drop in estrogen and androgen levels following oophorectomy, and systemic fatigue/toxicity associated with chemotherapy.²⁰ The literature reports that loss of sexual desire, vaginal dryness, and dyspareunia (painful sexual intercourse) are among the most common problems experienced by women undergoing gynecologic cancer treatment, and that these symptoms cause patients to develop negative and hesitant attitudes toward their sexual lives ^{17,18} .

Furthermore, the high average negative score obtained from the "Attitude Toward Sexual Life" subscale indicates that the issue is not limited to the physiological dimension but also involves psychosocial and cultural dimensions. Surgical interventions on the female genital organs can lead to a distorted body image, a loss of the sense of femininity, and feelings of inadequacy or guilt toward one's partner.¹⁴ In particular, the perception of sexuality as a taboo in conservative or traditional societies, coupled with patients' reluctance to share their negative experiences with their partners or healthcare professionals, contributes to the reinforcement of negative attitudes toward sexual life. ^{16,23}

In our study, the hierarchical multiple linear regression analysis conducted to identify the sociodemographic and educational factors predicting gynecological cancer patients' attitudes toward their sex lives clearly demonstrates the decisive role of the education provided to patients.

It was found that the sociodemographic variables included in the model in the first step (Model 1) explained 35.6% of the variance in attitude scores ($R^2=.356, p<.001$). Upon detailed examination of the independent variables in Model 1, it was observed that educational status ($\beta=-.446, p<.001$) and age ($\beta=.213, p=.001$) significantly predicted negative attitude scores, whereas employment status and

income level did not make a significant contribution to the model. This finding indicates that as patients' educational level increases, their negative attitudes toward sexual life decrease, while negative attitudes increase with age. The literature also emphasizes that women with higher levels of education have better health literacy, greater access to information about sexual health, and stronger communication skills regarding such topics, enabling them to cope more easily with psychosexual problems arising from treatment.^{16,17} Advancing age, however, emerges as an independent risk factor that increases negative attitudes, both physiologically—due to the worsening of menopausal symptoms and atrophy—and generationally and culturally, as sexuality is viewed as a difficult topic to discuss.^{13,18}

Model 2, created by adding the variable “status of receiving education on the impact of cancer on sexuality” in the second step, increased the total explained variance to 55.6% ($R^2=.556, p<.001$). Even after controlling for the effects of sociodemographic variables, the inclusion of the status of receiving education regarding sexual life in the model resulted in a 20% increase in variance explained—an increase that was both significant and independent ($\Delta R^2=.200, p<.001$). Upon examining the coefficients of Model 2, it was determined that whether patients received education regarding the impact of cancer on their sex life was the strongest independent predictor of a negative attitude ($\beta=.517, p<.001$). With the inclusion of the education variable, the significant predictive roles of age and patient education level were maintained ($\beta=.128$ and $\beta=-.248$), although their effect coefficients decreased. This finding demonstrates that, regardless of sociodemographic factors, structured patient education plays a dominant and protective role in changing patient attitudes.

Numerous studies in the literature examining the effectiveness of sexual health education and psychoeducational interventions provided to oncology patients support our findings. The literature reports that education and counseling initiatives for women undergoing cancer treatment significantly reduce patients' dysfunctional attitudes, anxiety, and taboos regarding sexual life ^{14,15}. While patients who did not receive education tended to perceive treatment-related vaginal atrophy, dyspareunia, and loss of libido as a “crisis or helplessness,” those who received education viewed these changes as an expected part of the process and became more open to solutions (such as the use of lubricants and communication techniques) ^{12,23}.

CONCLUSION AND RECOMMENDATIONS

This study determined that the attitudes toward sexuality among women diagnosed with gynecological cancer are influenced by age, educational level, cancer stage, and whether they received education regarding the effects of cancer on sexual life. It was found that as women's age increased, their negative attitudes toward sexual life increased, while as their educational level rose, their negative attitudes decreased. Furthermore, it was observed that women diagnosed with advanced-stage cancer who had not received education regarding the effects of gynecological cancer on their sexual lives had more negative attitudes toward sexuality. The fact that the status of receiving education regarding sexuality was the independent variable that predicted attitude scores most strongly and in a positive direction

highlights the importance of education in meeting the sexual health needs of women with gynecological cancer.

It is recommended that sexual health be incorporated as a routine and comprehensive part of the care process for women diagnosed with gynecological cancer. It is particularly important to prioritize the assessment of women who are older, have a lower level of education, have been diagnosed with advanced-stage cancer, and have not received education on sexual health. It is recommended that healthcare professionals—particularly oncology and women’s health nurses—develop and implement structured education and counseling programs addressing the sexual issues women may encounter during their illness and treatment. In future research, it would be beneficial to evaluate the effects of these education and counseling initiatives on women’s attitudes toward sexuality and the quality of their sexual lives through experimental and longitudinal studies.

Declarations

Data Availability

Data are available from the corresponding author upon reasonable request.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Ethical Approval

Approval was obtained from the Istanbul Okan University Ethics Committee on March 5, 2025, prior to the start of the study. Permissions to use the scales employed in the study were obtained. All participants were provided with an explanation of the study’s purpose, and their agreement to participate in the study was confirmed by their signing the informed consent form. The study was conducted in accordance with the principles of the Declaration of Helsinki. As data were collected via an online survey, the CHERRIES (Checklist for Reporting Results of Internet E-Surveys) guidelines were followed.

CRedit authorship contribution statement

Conceptualization: KDB, EMT

Methodology: KDB, EMT

Validation: KDB, EMT

Formal Analysis: KDB, EMT

Investigation: KDB, EMT

Resources: KDB, EMT, NAD

Data Curation: KDB, EMT

Writing—Preparation of the Original Draft: KDB, EMT, NAD

Writing—Review and Editing: KDB, NAD

Visualization: KDB, NAD

Supervision: KDB, NAD

Declaration of Conflicts of Interest

The authors declare no potential conflicts of interest regarding the research, authorship, or publication of this article.

Acknowledgments

The authors would like to thank all the women who participated in this study.

Consent for Publication

Not Applicable.

References

1. Hallaç S, Öz F. Existential anxiety during the genital cancer diagnosis process. *Curr Approaches Psychiatry*. 2011;3(4):595–610.
2. Mercadante S, Vitrano V, Catania V. Sexual issues in early and late-stage cancer: A review. *Support Care Cancer*. 2010;18(6):659–65. <https://doi.org/10.1007/s00520-010-0814-0>.
3. Bilge Ç, Kaydırak MM, Aslan E. The effects of gynecological cancer on sexual life. *Süleyman Demirel Univ J Health Sci*. 2016;7(3):31–8.
4. Teskereci G, Kulakaç O. (2018). Life experiences of caregivers of women with gynecological cancer: A mixed-methods systematic review. *Eur J Cancer Care*, 27(1), e12456.
5. Yıldız Y, Alacacioğlu A, Varol U, Küçükzeybek Y, Aşık N, Salman T, Tarhan MO. Evaluating sexual satisfaction and quality of life in patients with gynecological cancer. *Acta Haematologica Oncologica Turcica*; 2018.
6. Akıncı ÇA, Aksoy SD. Sexual problems in women with cancer. *Jaren*. 2019;5(2):156–62. [10.5222/jaren.2019.09709](https://doi.org/10.5222/jaren.2019.09709).
7. Ölçer Z, Oskay Ü. Sexual counseling for cancer patients based on the BETTER model. *Androl Bul*. 2020;22(3):177–82.

8. Şahan FU, Er Korucu A. Sexual health during the survival process after gynecologic cancer: The nurse's role in holistic care. *Androl Bull.* 2025;27(1):45–52.
9. Akyüz A, Güvenç G, Üstünsöz A, Kaya T. Living with gynecologic cancer: experiences of women and their partners. *J Nurs Scholarsh.* 2008;40(3):241–7.
10. Vardar O, Serçekuş P. Experiences of Muslim women living with gynecologic cancer and their family caregivers. *Int J Palliat Nurs.* 2023;29(5):225–34.
11. Utkulu I. A Study on the Development of a Scale Measuring Attitudes Toward Sexuality in Gynecologic Cancers. Master's Thesis. Gedik University Graduate School of Education. Istanbul, 2024.
12. Abbott-Anderson K, Kwekkeboom KL. A systematic review of sexual concerns reported by gynecologic cancer survivors. *Gynecol Oncol.* 2012;124(3):477–89.
13. Del Pup L, Nappi RE, Biglia N. Sexual dysfunction in gynecologic cancer patients. *Eur J Gynaecol Oncol.* 2017;40(1):5–11.
14. Stabile C, Goldfarb S, Baser RE, Goldfrank DJ, Abu-Rustum NR, Barakat RR, Carter J. Sexual health needs and educational intervention preferences for women with cancer. *Breast Cancer Res Treat.* 2017;165(1):77–84.
15. Cianci S, Tarascio M, Arcieri M, La Verde M, Martinelli C, Capozzi VA, Ercoli A. Post-treatment sexual function and quality of life of patients with cervical cancer: a systematic review. *Medicina.* 2023;59(4):704.
16. Akkuzu G, Talas MS, Ortac F. Functional status in Turkish women with gynecological cancer. *Asian Pac J Cancer Prev.* 2014;15(5):2045–9.
17. Boyraz HG, Erbil N. The PLISSIT Model for Sexual Counseling in Gynecologic Cancers. *J Women's Health Nurs.* 2023;9(2):64–71.
18. Reis N, Beji NK, Coskun A. Quality of life and sexual functioning in gynecological cancer patients: results from quantitative and qualitative data. *Eur J Oncol Nurs.* 2010;14(2):137–46.
19. Akdeniz N, Eren H. The effect of sociodemographic factors on quality of life and sexual health in women with gynecological cancer. *Anatol J Nurs Health Sci.* 2018;21(2):110–8.
20. Cleary V, et al. Psychosexual impact of gynecological cancer diagnosis and treatment. *Int J Gynecol Cancer.* 2017;27(9):2011–8.
21. Mishel MH. Uncertainty in illness. **Image: J Nurs Scholarship**. 1988;20(4):225–32.
22. Rathod AD, et al. Assessment of sexual dysfunction in gynecological cancer survivors and the impact of counseling. *J Mid-life Health.* 2020;11(2):85–91.
23. Gilbert E, et al. Sexuality after cancer: A qualitative study of health care professionals' views. *Oncol Nurs Forum.* 2016;43(5):603–11.