Comparison of the Effect of Sexual Counseling Based on BETTER and PLISSIT Models on Sexual Assertiveness of Women with Breast Cancer after Mastectomy

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Abstract

Introduction: Sexual changes in breast cancer occur after diagnosis and treatment include mastectomy. Sexual assertiveness is an effective factor in sexual satisfaction that means the ability to convey sexual feelings, beliefs, and thoughts and logically defend sexual rights. The present study aimed to compare the effectiveness of individual sexual counseling using the BETTER model with individual sexual counseling using the PLISSIT model in terms of increasing sexual assertiveness.

Materials and Methods: The present quasi-experimental intervention was conducted in Mashhad in 2021, and 78 mastectomized women with breast cancer were randomly assigned to two groups: BETTER and PLISSIT. Both groups received four individual counseling sessions of 60-90 minutes one week apart. The research tools included demographic information form, female sexual function index (FSFI), and the Hulbert index of sexual assertiveness (HISA). Changes in the mean scores of sexual assertiveness between the two groups were evaluated before and 4 weeks after the intervention, and the mean changes were compared between the groups. Data analysis was conducted using the Kolmogorov-Smirnov test, independent t-test, paired t-test, and Chi-square tests using SPSS 25 ($P<0.05$).

Results: The mean scores of sexual assertiveness were not significantly different between BETTER (46.7) and PLISSIT (43.07) groups before the intervention ($P=0.253$); however, the mean scores of sexual assertiveness in the BETTER group (54.8) and the PLISSIT group (48.6) were significantly different 4 weeks after the intervention. ($P<0.001$)

Conclusion: The results indicated that sexual counseling based on the BETTER model was more effective in increasing the sexual assertiveness of mastectomized women with breast cancer than counseling by the PLISSIT method.

Introduction

Sexual changes in breast cancer occur after its diagnosis and treatment include mastectomy and are affected by various factors, such as decreased sexual desire, fear of body deformity, fear of rejection by a sexual partner, and sexual dissatisfaction(1). Sexual assertiveness is an effective factor in sexual satisfaction that means the ability to convey sexual feelings, beliefs, and thoughts, and to defend sexual rights logically(2). Alberti and Emmons (1970) defined sexual assertiveness as individuals' ability to act on and stand up for their interests without anxiety and to express their rights without violating others' rights(3). Sexual assertiveness is defined as a psychosocial feeling about individuals' perception or interpretation of how their feelings are expressed in marital relationships. Sexual assertiveness is regarded as individuals' ability to have sex to meet sexual needs and to guide sexual behavior with their spouses(4).

Asadi (2011) found that sexual assertiveness was a significant factor in sexual and marital satisfaction(5). Mirshamshiri (2015) found that increase of sexual assertiveness decreased marital conflict and burnout(6). Examination of the role of sexual assertiveness in women's sexual desire,

Hurlbert found that women with high sexual assertiveness had higher sexual activity, orgasm, sexual satisfaction, and marital satisfaction(2).

Difficulty in communicating and expressing needs and wants is the main cause of sexual and relationship problems after cancer treatment. Akbari et al. (2020) indicated that sexual assertiveness was a major factor in sexual satisfaction, and since the sexual activity pattern was unsatisfactory in most women with breast cancer, their sexual assertiveness was also low(7). Studies indicated that both women and their sexual partners used the silent method for coping and compliance, and even avoided telling healthcare providers about sexual issues(8).

Yusuf et al. (2013) found that women had changes in their perception of their body image owing to breast loss and changes after surgery, considered themselves incomplete and unattractive, and worried that their husbands would reject them due to the changes(9). If women talk to their sexual partners about their conditions, abilities, disabilities, and limitations after completing their cancer treatment, and in other words, obtain their sexual assertiveness, they will be able to manage changes in sexual relations easily and better(8).

Studies demonstrate that lower sexual assertiveness is associated with higher marital incompatibility, psychological distress, and emotional divorce(6). Taheri (2020) found that higher sexual assertiveness decreased emotional divorce(10). Therefore, the design and implementation of a counseling-educational method are essential to promote sexual relations and intimacy in women with breast cancer. The PLISSIT model (Permission, Limited Information, Specific suggestions, and Intensive therapy) has been widely used in sexual counseling(11). The BETTER model is another approach to sexual counseling in cancers(12). and consists of 6 stages as follows: The first stage (Bringing up): Discussing the issue of sexual relations with the patient. The second stage (Explaining): Counseling on the importance and impact of sexual issues on quality of life. The third stage (Telling): Informing and explaining sexual problems. The fourth stage (Timing): Paying attention to scheduling. The fifth stage (Educating): Educating about changes in sexual function due to cancer and its treatments, and recognizing and correcting misconceptions. The sixth stage (Recording): Recording important aspects of discussions, evaluations, and interventions.

The PLISSIT model is a simple way to address sexual issues(13); however, it has a linear format, and due to entering from one stage to another, the therapist cannot recognize that it may be necessary to return to the previous stage to address the patient's sexual concerns. This model places little emphasis on patient feedback. A limitation of the model is that due to the need for knowledge and skills at the third and fourth levels of PLISSIT, midwives and nurses can only intervene in the first and second stages(14, 15).

On the contrary, the BETTER model is defined as a client-centered model and is a tool to facilitate the express of sexual issues between the client and the therapist. Martinez (2007) maintains that this model has been introduced owing to its simplicity and focus on improving sexual discourse. The emphasis of the BETTER model is on recording conversations to expand and advance sexual discourse. This model

provides a wider range of sexual negotiations based on the client's schedule and necessary information(12, 16).

Given the cultural beliefs of the Iranian society about the difficulty of discussing sexual function problems, especially after changes in the appearance of sexual organs and the different levels of client participation in counseling in PLISSIT and BETTER models, the researcher aimed to conduct research in order to compare the effect of counseling based on PLISSIT and BETTER models on women's sexual assertiveness after mastectomy.

Methods

The present quasi-experimental study examined 78 mastectomized women who visited the Cancer Clinic of Omid Hospital in Mashhad from May to January 2021. Inclusion criteria of the study were as follows: informed consent to participate in research, literacy, being married, being at the age of 18-49, passing at least one year after mastectomy, sexual function score of less than 28, non-use of drugs and alcohol in wife and husband, no use of drugs affecting sexual function by the person or her husband, not receiving sexual counseling during the last 6 months, not suffering from psychiatric illnesses, and moderate and severe depression, and lack of experience of accidents in the last 1 month. Exclusion criteria were as follows: absence from a counseling session, recurrence of symptoms of breast cancer or its metastasis or other cancers, and death of the patient. The sample size was obtained 33 per group according to one study conducted by Karimi et al(17). Using the formula of the mean of two independent populations, the minimum sample size, and considering a confidence interval of 95%, and test power of 80%. By considering the 20% probability of loss, the final sample size was 40 per group and a total of 80 individuals. Sampling was performed after obtaining the approval of the University Ethics Committee and submitting a written letter of recommendation from the School of Nursing and Midwifery to the Breast Cancer Clinic of Omid Hospital and obtaining their consent. First, approximately 400 cases of breast cancer patients were studied from 2011 to 2020, and approximately 250 patients with primary conditions were selected. Then, they were contacted, and 80 patients with the inclusion criteria were selected, and written consent was obtained from them after providing the necessary information about the study and its objectives. They completed the questionnaires after receiving information on how to respond to each questionnaire and assuring them that the information would be confidential. After selecting eligible individuals, random allocation of individuals to the two consulting groups, BETTER and PLISSIT, was performed in random blocking using the table of random numbers from the website of www.randomization.com. The created sequences were recorded on small sheets and placed in sealed envelopes. The envelopes were opened according to the order of the arrival of the research units, and the assigned group was revealed. The final study was conducted on 78 individuals due to the loss of 2 units (One in the BETTER group due to death, and another in the PLISSIT group due to absence from counseling sessions).

The research tools included the demographic information form, the female sexual function index (FSFI), and the Hulbert index of sexual assertiveness (HISA), which were completed by the units before the

intervention. The demographic information form included 37 questions prepared by studying new and valid references and articles, and its validity was confirmed by 7 faculty members of Mashhad University of Medical Sciences. The FSFI included 19 questions in six fields of sexual desire, arousal, lubrication, orgasm, satisfaction, and pain during sexual intercourse. The reliability of the questionnaire was determined by Mohammadi (2008) using the internal consistency method by calculating the Cronbach's alpha coefficient of 0.7(18), and it was 0.87 in the present study according to Cronbach's alpha. The HISA consisted of 25 questions with a score ranging from 0 to 100. The higher score indicated higher sexual assertiveness, and the lower score exhibited lower sexual assertiveness(19). The reliability of the tool was 0.83 using the Cronbach's alpha coefficient in one study conducted by Azmoude et al.(20), and it was 0.87 by the Cronbach's alpha in the present study.

In the PLISSIT counseling group, four 60-90-minute individual counseling sessions were held one week apart. Permission stage: In a safe and trustworthy environment, the counselor allows the clients to talk about sexual issues and express their concerns and problems. Giving limited information: The counselor provides limited, real, and fact-based information in response to a question or potential sexual problems admitted by the clients. Specific suggestions: At this stage, the counselor offers specific and appropriate suggestions for the patient's sexual problem. The main solution to the problems at this stage is developed by the authorities' decisions and the counselor's guidance. Intensive therapy: If the problem persists, the clients are referred to a sex therapist or specialist.

In the BETTER counseling group, four 60-90-minute sessions of individual counseling were held one week apart based on the BETTER model as follows: Bringing up: Discussing the issue of sexual relations with the patient and reassuring the patients for being comfortable in expressing their sexual issues, then evaluating sexual beliefs and activities in the present. Explaining: The counselor explains the importance and impact of sexual issues on quality of life and tells the clients that they are completely free to talk about it. It helps to normalize sexual discourse and reduce the clients' sense of shame. Telling: Informing and explaining the patients' sexual problems using available scientific references. Timing: Paying attention to scheduling and discussing when the person is ready. Since sexual relation is an ongoing process, a counselor is available at any time to address the clients' concerns and answer their questions. Educating: Educating the patients about potential changes in sexual function due to cancer and its treatments, and recognizing and correcting the clients' misconceptions about sex after cancer. Recording: Recording important aspects of discussions, evaluations, and interventions.

Four weeks after the intervention, the HISA was re-completed by the research units.

After collecting and encoding the study data, they were inserted into the computer and analyzed by the Kolmogorov-Smirnov test, paired t-test, independent t-test, and Chi-square in SPSS 16.

Results

The mean±standard deviation of women's age was equal to 41.3±4.6 and 42.2±4.3 years in BETTER and PLISSIT groups, respectively. The mean±standard deviation of the duration of marriage was 18.8±6.8

and 19.8±6.8 years in BETTER and PLISSIT groups, respectively. The mean±standard deviation of weight was 73.5±12.3 and 69.8±9.3 years in BETTER and PLISSIT groups, respectively. The two groups were homogeneous in terms of other demographic characteristics that were examined and compared before the intervention (Table 1). Before the intervention, the mean score of sexual assertiveness was 46.7 and 43.07 in BETTER and PLISSIT groups, respectively. The independent t-test indicated no significant difference (P=0.253). Four weeks after the intervention, there was a significant difference in the mean scores of sexual assertiveness in both groups, but the difference was greater in the BETTER counseling group: 54.8 vs. 48.6 (P=.027). After the intervention, sexual assertiveness increased by 8.07 and 5.58 points in BETTER and PLISSIT groups, respectively. The independent t-test revealed a significant difference in sexual assertiveness scores (P=0.026). The paired t-test indicated a significant difference in the sexual assertiveness scores of both groups compared to the time before the intervention (p<0.001) (Table 2).

Table 1: Demographic characteristics of the participants in the BETTER and PLISSIT groups

P value	PLISSIT group n (%)	BETTER group n (%)	Variable
			Education level
.867	(25.6)10	(25.6)10	Under Diploma
	(41.0)16	(46.2)18	Diploma
	(33.3)13	(28.2)11	University education
			Spouse's education level
.862	(30.8)12	(30.8)12	Under Diploma
	(33.3)13	(38.5)15	Diploma
	(35.9)14	(30.8)12	University education
			Occupational status
.122	(79.5)31	(74.4)29	housewife
	(2.6)1	(15.4)6	worker
	(17.9)7	(10.3)4	Employed
			Spouse's occupational status worker
	(63.9)27	(61.5)24	Employed
.348	(20.5)8	(28.2)11	Retired
	(0)0	(5.1)2	Unemployed
	(10.3)4	(5.1)2	
			Separate room for sexual intercourse
.345	(59)23	(69.2)27	yes
	(41)16	(30.8)12	No
			drugs affecting on sexual function
1			yes
	(7.7)3	(10.3)4	No
	(92.3)36	(89.7)35	
			Chemotherapy history
	(92.3)36	(89.7)35	yes

1	(7.7)3	(10.3)4	No
			Radiation therapy
.815	(64.1)25	(61.5)24	yes
	(35.9)14	(38.5)15	No
			Hormone therapy
.624	(66.7)26	(71.8)28	yes
	(33.3)13	(28.2)11	No
			Vaginal dryness
.092	(87.2)34	(71.8)28	yes
	(12.8)5	(28.2)11	No
			Hot flash
.481	(84.6)33	(92.3)36	yes
	(15.4)6	(7.7)3	No
			Vaginal burning
.815	(38.5)15	(35.9) 14	yes
	(61.5)24	(64.1)25	No

P	T	PLISSIT group	BETTER group	Variable
.393	- .860	4.3 ± 42.2	4.6± 41.3	Age
.132	1.524	9.3 ± 69.8	12.3± 73.5	Weight
.523	- .642	6.8 ± 19.8	6.8± 18.8	Marage date

Table 2: Mean (SD) of sexual assertiveness before and after the intervention in the PLISSIT and BETTER group

Result	PLISSIT	BETTER	sexual assertiveness
t-test	n=39	n=39	
P=.253, t=1.151, df=76	43.07±13.4	46.7±14.6	Before the intervention
P=.027, t=2.255, df=76	48.6±12.5	54.8±11.5	after the intervention
P=.026, t=2.266, df=76	5.58±4.7	8.07±4.9	Changes before and after the intervention between the groups
	p<0.001	p<0.001	**Result**
	t=-7.357 , df=38	t=-10.192 , df=38	**paired t-test**

Discussion

The present study aimed to compare the effect of sexual counseling based on BETTER and PLISSIT models on mastectomized women's sexual assertiveness. The results demonstrated that the BETTER model had a more significant increase in sexual assertiveness than the PLISSIT model. It appears that the BETTER model can improve the conversation between the counselor and the client about sexual issues by creating a safe and intimate atmosphere, since the BETTER model is client-centered and provides a wide range of sexual negotiations based on the client's schedule and information. Since there was no study to compare the effects of the above two models on sexual assertiveness in women with breast cancer, we reviewed the most relevant research in this field. One quasi-experimental study conducted by Akbari et al. indicated that the four-factor psychotherapy had no effect on the sexual assertiveness of women with breast cancer(7). In this study, the sexual function scores of women were not screened, while only individuals with a score less than 28 in the FSFI were included in the present study. Akbari argued that the quality of women's sexual function was affected by cancer treatments and problems, such as body image change, atrophy, vaginal dryness, and numbness of the breasts, and this factor was an obstacle to sexual assertiveness and expression of sexual desire; hence, the use of special strategies and the participation of medical staff, along with psychotherapy appear necessary. Nabila El-sayed demonstrated that the implementation of the PLISSIT model was effective in improving sexual function, sexual satisfaction, and body image in breast cancer patients undergoing various treatments(21). The findings of this study were consistent with those of the present study on the effectiveness of the PLISSIT model; however, one study conducted by Merghati Khoei, aiming at comparing sex counseling based on the PLISSIT model, and group sex education in Iranian women with breast cancer, indicated that although the PLISSIT model was an effective and well-known model, group counseling based on the sexual health model in the Iranian culture was more effective in improving

sexual behaviors(22). The results of this study were consistent with those of the present study, revealing the effectiveness of the BETTER counseling model that was more in line with the Iranian culture. In many societies, women have difficulty in sexual assertiveness and have low self-esteem, and it is difficult for them to express their needs or maintain their independence in marital relationships. Therefore, counseling approaches, including BETTER, have been used to encourage couples to discuss sexual issues with each other and with healthcare providers. In this regard, Shahin et al. found that nursing counseling with the BETTER model had a considerable effect on improving sexual desire, sexual satisfaction, and psychological status of women with breast cancer. They indicated that although the BETTER model was designed for a specific group of patients and specialists, it had also been considered in other chronic diseases owing to its simplicity and focus on sexual discourse(23). Zamani et al. (2020) found that the BETTER model-based couple training and counseling were effective in improving sexual satisfaction of women with type 1 diabetes, and the effect remained until 3 months after the intervention(24). The result was consistent with the result of the present study. Karakas et al. found that the BETTER model improved infertile women's sexual function and satisfaction. They stated that the BETTER model provided a suitable treatment environment for solving sexual function problems and helped women to express their sexual problems more easily(25). Their results were consistent with the results of the present study. Karimi et al. also compared the two counseling methods, BETTER and PLISSIT, in the sexual assertiveness of women with sexual problems after childbirth, and found that the BETTER model was more effective than the PLISSIT model in increasing women's sexual assertiveness, and their results was consistent with those of the present study(17).

The BETTER model's view about sexual issues is more than just having sex and it is a discussion of the role of sexuality, intimacy in life, and most importantly, the recording of these conversations to expand and advance sexual discourse between the client and the counselor. In the BETTER model, the counselor starts a conversation, clarifies the importance of sexual issues to patients, encourages women to talk more about their problems, and attempts to break the taboo of discussing sexual problems, thereby eliminating the barriers to couples' communication. Hence, it leads to a higher desire for sexual assertiveness, and ultimately increases the couple's sexual satisfaction.

The strength of the present study was that it first compared the two counseling methods, BETTER and PLISSIT, in women with breast cancer who underwent a mastectomy. The research limitation was the absence of husbands in the study. Given the roles of husbands in couple communication, and the importance of mutual communication in sexual intimacy, the presence of both couples will help to make educational-counseling interventions more effective.

Conclusion

The BETTER model can have a considerable impact on increasing the sexual assertiveness of women with breast cancer by focusing on sexual relations, expressing sexual needs and preferences, paying attention to the sexual counseling timing, emphasizing the record of evaluations, and providing feedback. Thus, it can be used as an advanced easy-to-use framework for healthcare providers. It is suggested that

a study similar to the present study be conducted in the presence of couples to compare BETTER and PLISSIT methods regarding sexual assertiveness.

Declarations

Consent for publication: The written informed consent was obtained from all subjects.
Availability of data and materials: The datasets used and/or analysed during the current study available from the corresponding author on reasonable request.
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Negar Asgharipour: Psychological Advisor , methodology

Jamshid Jamali: Data curation , formal analysis, software

Ali Taghizadeh kermani: Oncology Consultant , conceptualization

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Ethical statement:

- All methods were carried out in **accordance with the Declaration of Helsinki**
- All experimental protocols were **approved by Mashhad University of Medical Sciences Ethics Committee with number IR.MUMS.REC.1399.681.**
- The **written informed consent** was obtained from all subjects.

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