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Accounting for Sexual Issues Related to Cancer

A Discursive Psychological Approach to Online Talk Between Women in Heterosexual Relationships

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Abstract

Cancer and its treatments cause significant changes in sexuality that affect the quality of life of both patients and their partners. As these issues are not always discussed with healthcare

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professionals, cancer patients turn to online health communities to find answers to questions or for emotional support pertaining to sexual issues. By using a discursive psychological perspective, we explore the social actions that participants in online health forums perform when discussing sexuality. Data were collected by entering search terms in the search bars of three online health forums. Our analysis of 213 threads, containing 1,275 posts, provides insight into how participants who present themselves as women with cancer account for their sexual issues and, in doing so, orient to two intertwined norms: Having untroubled sex is part of a couple's relationship, and male partners are entitled to having untroubled sex. We discuss the potential harmful consequences of orienting to norms related to sexual behaviour. Yet, our findings can also help healthcare professionals in broaching the topic of sexuality in conversations with cancer patients. The insights of this study into what female patients themselves treat as relevant can assist health professionals in better aligning with patients' interactional concerns.

Keywords

Online health forums, cancer patients, discursive psychology, sexuality, sexual health.

In 2020, approximately 19.3 million people worldwide (Sung et al., 2021), and approximately 2.7 million people in the European Union, were diagnosed with cancer (European Cancer Information System, n.d.). As the world is faced with population growth and an ageing population, the absolute number of cancer diagnoses will rise over time (Sung et al., 2021). Despite this increase, cancer patients have a greater life expectancy today due to early detection and advanced treatments (Foster et al., 2018). This has resulted in a greater attention to the quality of life (QoL) of people living with cancer.

Cancer and its treatments cause significant problems in sexuality (Mercadante et al., 2010; Sadovsky et al., 2010). In this study, we treat sexuality as encompassing sexual function, sexual self-concept, and sexual relationships, with intimacy being a component of the latter (de Vocht, 2011; Woods, 1987). Sexuality is a multidimensional concept and a change in one dimension will affect the others accordingly, having an impact on one's sexual health (Cleary & Hegarty, 2011), and most likely on one's QoL (Tierney, 2008). Attention is increasingly paid to targeting the psychosocial issues of cancer, such as sexual issues, for instance in the area of psycho-oncology (Lang-Rollin & Berberich, 2018). However, success hinges on the willingness and ability of healthcare professionals (HCPs) to discuss sexuality (Ratner et al., 2010). Although HCPs in oncology increasingly acknowledge the importance of discussing sexuality throughout the course of the disease trajectory, research indicates that this subject is often neglected in practice (Gilbert et al., 2016; Lindau et al., 2011). This might be due to HCPs' feelings of discomfort, or a lack of time and training (Krouwel et al., 2015; Ussher et al., 2013), the presence of a third party, or a different language/ethnicity (Krouwel et al., 2015). As a result, many cancer patients experience unmet needs regarding sexual health communication, as they search for answers to questions such as "are my sexual problems normal?" (Albers et al., 2020; Hordern & Street, 2007).

Online Health Communities

Patients increasingly find answers to these questions by participating in online health communities (OHCs; Kaal et al., 2018). Through a shared online communication medium,

these communities provide spaces for their members to ask and search for information, and to share insights and experiences concerning a health- or illness-related topic (Johnston et al., 2013; Loane & D'Alessandro, 2013). Research has shown that cancer patients and their partners searched for information online when they felt that their healthcare provider did not sufficiently discuss sexuality with them (Gilbert et al., 2016). Moreover, the fact that people who experience sexual problems are unsure on how to handle this complicated subject in conversations with HCPs leads them to engage in OHCs (Basinger et al., 2021). In general, people experiencing a sensitive health issue (e.g., a condition described as stigmatising, such as breast cancer) often think of online support as a safer option than face-to-face support (Davison et al., 2000).

This indicates that cancer patients might feel more comfortable discussing their sexual issues online. OHCs additionally provide cancer patients with easy access to information and support (Blank & Adams-Blodnieks, 2007; Wiljer et al., 2011), can help in reassuring participants about their sexual health (Basinger et al., 2021), and even have the potential to improve patients' QoL (Osei et al., 2013). Nonetheless, discussing sexuality in OHCs is not without its downsides. Participants' interactional behaviours, for instance, might have a stigmatising effect, as previous research has indicated that euphemisms (e.g., "down there") and slang are used when discussing sexuality on online health forums (OHFs; Basinger et al., 2021).

Discursive Psychology

In this study, we use the theoretical, methodological, and analytical principles of *discursive psychology* (DP) (Wiggins, 2017) to analyse interactions on OHFs that are part of OHCs. DP focuses on naturally occurring interaction rather than researcher-driven questionnaires or interviews (Hepburn & Potter, 2003). Drawing upon DP to examine discussions on OHFs provides us with an understanding of what participants themselves make relevant in interactions about sexuality and the social actions they perform (Potter, 2012). Additionally, analysing these online interactions can reveal interactional practices that are conceivably not available from medical consultations, presumably because HCPs are seen as being primary responsible for broaching the subject of sexuality during these consultations (Ussher et al., 2013). Furthermore, online forums allow participants to talk about sensitive topics that might be more difficult to discuss in person (Robinson, 2001), which may result in participants discussing these issues in a more candid way than in a face-to-face environment.

Literature on the social actions that are performed in online discussions on sexuality in relation to cancer is lacking. Nevertheless, contemporary research has increasingly focused on how health- and illness-related topics are discussed in online media and online communities. Earlier studies have examined, for example, thematic features of cancer patients' personal narratives on YouTube (Chou et al., 2011) and blogs (Keim-Malpass et al., 2013). This novel approach can help HCPs to better understand and address patients' concerns through listening to patients' own perspectives. Other studies have used DP and conversation analysis to analyse online discourse, focusing in particular on discourse as social practice. For instance, it has been studied how patients construct identities (Lamerichs & van Hooijdonk, 2019) or manage accountability for being on sick leave (Flinkfeldt, 2011). In addition, the type of study that examines social interaction online can result in advice applicable in healthcare practice. Advice, for example, which is derived from the way patients present themselves in online talk.

We aim to explore the social actions participants in OHFs perform when discussing sexuality in the face of cancer. DP can additionally reveal what participants treat as normal or deviant when accounting for their issues and behaviours, allowing us to gain insight into the norms that participants orient to online. In this paper, norms are treated as something participants in talk can employ, either consciously or unconsciously, as resources in explaining actions; in explaining, describing, and accounting for actions, people show an orientation towards certain norms (Edwards, 1997). So, rather than actions being governed by norms, "actions are done and described in a way that display their status with regard to some rule or expectation" (Edwards, 1997, p. 7). We will not make claims about causal relationships between norms and intentions; DP's approach to norms is not a cognitive one. Previous work in DP has revealed, for instance, how participants in online forums show an orientation towards a norm of being critical (Versteeg et al., 2018), but also how norms for legitimate membership are negotiated when interacting with new members of an online support group (Stommel & Koole, 2010). In line with this research that shows participants orienting to norms, in this study, we focus on what participants orient to themselves when discussing sexuality. Finally, our insights into how patients present themselves may offer HCPs tools to engage patients in conversations about sexuality.

Methods

Data Collection

This study focuses on interactional data from three Dutch OHFs, two of which focus on cancer (www.kanker.nl and www.diagnose-kanker.nl). The third forum encompasses a wide range of health issues but contains discussions on various cancer types (www.dokter.nl). These OHFs enable individuals dealing with cancer to discuss all kinds of topics, such as treatment options and QoL issues. This text-based interaction can be described as *asynchronous*: Instead of happening in real time, members post messages in threads over time (Antaki et al., 2005; Kiyimba et al., 2019). All three selected forums were first screened to determine whether they contained discussions about sexuality. We expect these forums to provide a comprehensive impression of the way people dealing with cancer discuss sexuality online, especially since one of these forums is part of a large online cancer platform with 30,000 participants and 550,000 unique visitors per month (kanker.nl, n.d.). Moreover, multiple Dutch cancer patient organisations refer patients to this specific forum for peer support. Another forum is part of a large and wide-ranging health community in the Netherlands, and the last forum was selected because of its specific focus on cancer. At first glance, all OHFs appeared to contain a substantial number of posts relating to cancer and sexuality.

Data were collected retroactively via entering the following search terms in two of the three forums: sex, sexual, sexuality, making love, intercourse, and intimacy. On one of these forums, similar words, such as coitus, were automatically included when searching for the aforementioned terms. On the second forum, these terms were entered in the search bar, but this did not yield any results. For the sake of thoroughness, we entered a number of other terms such as 'relationship', but this resulted in too many off-topic threads. Therefore, we did not include these terms. Since the third forum did not allow for a systematic search using search terms, on this forum we conducted a screening of the titles of the threads about cancer.

Potentially relevant posts were read in more detail. We developed the following inclusion criteria:

1. Posts had to be related to sexuality during or after cancer, meaning that threads about early stages of cancer or fear of having cancer were not included;
2. at least one post in a thread had to contain talk about sexuality; and
3. when a post contained talk about sexuality, the surrounding interaction was also taken into account.

This allows for an analysis of the way participants orient to each other's utterances regarding sexuality. Finally, a corpus of 213 threads containing 1,275 posts, published between 2002 and the start of June 2021, remained for analysis.[1] Threads ranged from 1 post to 41 posts, with a mean of 6 posts and a median of 4 posts.

Analytical Procedure

DP focuses on discourse as social practice. Rather than viewing language as a representation of a cognitive state or process, language is seen as action-oriented: People do things with language (i.e., they perform social actions: they blame, ask for advice, account for behaviour and so forth; Potter, 2012). Moreover, DP is concerned with stake and accountability. Stake refers to the notion that the things participants in interaction do or say may be considered as a product of stake or interest. Additionally, accountability is seen as something speakers frequently attend to and manage. That is, people construct their talk in a way that manages blame and responsibility for behaviours or events (Edwards & Potter, 1992; Wiggins, 2017). This does not, however, imply that they are actually to blame or that their accounts are a representation of their thoughts or motivations (Wiggins, 2017).

These issues relating to potential accusations of stake, agency, or responsibility, are considered *interactional concerns* (Lamerichs et al., 2009). Participants anticipate these interactional concerns through their *interactional practices* (see Potter, 1996; Sneijder & te Molder, 2006). For instance, when discussing sexuality, participants might present sexuality as relatively less important in order to prevent being accused of giving this too much priority. So, central to a discursive psychological analysis is examining what people in interaction achieve by using language a certain way. In this way, we can uncover shared norms that participants in interaction, in this case interaction in OHFs, orient to.

Instead of working with pre-defined categories, a discursive psychological analysis involves examining what people make relevant themselves in their talk. This is a cyclical process: By reading, re-reading, and going back and forth through the data and interesting phenomena, we find patterns of talk (Wiggins, 2017). During our first readings of the data, one of the interesting phenomena was that cancer patients frequently made their partners relevant in talk about sexuality. Of the 1,275 posts, there were 105 threads containing 506 posts in which partners were mentioned. These were selected for further analysis. In examining these threads, we noticed that, when discussing their sexual issues, it was mostly participants who presented themselves as women with cancer[2] who referred to their male partners in such a way that showed they accounted for their issues and behaviour. We noticed that participants who presented themselves as male patients problematised sexual issues less than women, and instead discussed alternatives to coital sex, thus indicating male patients discussed issues in a

different way. We, therefore, decided to only focus on posts written by women with cancer who described themselves as being in a heterosexual relationship.

Our focus is on the sequential and rhetorical aspects of the utterances under examination. First, discourse can be understood by examining what precedes and follows the utterance under examination. The turn-by-turn analysis of discourse provides insight into the type of understanding that participants display of each other's turns (Wiggins & Potter, 2008). Subsequently, another important procedure is exploring alternative utterances to assess what other possible contrasting version is countered by the chosen formulation (Edwards, 1997). This allows us to understand the social actions performed and their interactional effects.

Ethical Considerations

There are ethical aspects to consider when collecting and analysing online interactions. First, it is essential to assess whether the online forum is considered public or private (Ditchfield, 2021; Kiyimba et al., 2019), since the use of private online interactions often implies needing informed consent (Ditchfield, 2021). On the other hand, people who find themselves in a public context, such as an OHF, can assume that others might observe their activities (Kiyimba et al., 2019). While two of the three forums were publicly accessible, it is plausible that users wrote their posts without intending or expecting to be the focus of research. Furthermore, posts might contain sensitive personal information. In light of this, we obtained informed consent from the administrators of the forums for the use and publication of the posts.[3] Moreover, on the forum that required an account to access most posts, users occasionally suggested to continue the conversation on a more private channel, indicating they are aware of the public nature of that forum. Furthermore, it is important to consider the anonymity of participants (Ditchfield, 2021). To that end, we applied pseudonyms in our results. Additionally, other potentially identifying characteristics are not present in the extracts, and the date and time of the interactions have been omitted.

Below, we present extracts to illustrate our findings. The extracts were originally written in Dutch but will only be shown in English. Since it is imperative to the analysis, translations are as literal as possible whilst still ensuring readability.

Results

Our analysis discusses the way women with cancer attend to the accountability of their sexual issues, and their way of dealing with these issues. Additionally, we show what happens when these women describe how their partners deal with the current status of their sex life. We demonstrate that the accounts female patients provide, give insight into interactional concerns that are at play when discussing sexual issues. How these sexual issues are described (i.e., the interactional practices performed) also reveal two norms that these women orient to. In what follows, we will first focus on representative extracts in which women orient to the norm that having untroubled sex is part of a couple's relationship, and second on those in which they orient to the norm that male partners are entitled to having untroubled sex.[4]

Norm 1: Having Untroubled Sex Is Part of a Couple's Relationship

The extracts below illustrate how patients orient to the norm that having untroubled sex is part of an intimate relationship. In their descriptions, patients convey what is troubled, or conversely

untroubled sex: sex, free of trouble. This "trouble" is defined by patients themselves, as will be seen in how they present their sexual problems. By making relevant their usual sexual behaviour (e.g., having sex a couple of times a week), and contrasting this with current practice (e.g., being less in the mood for sex), patients orient to the norm that having untroubled sex is part of their partnered relationship. In extract 1a, the patient describes not having sexual intercourse as a problem:

Extract 1a (from Anna)

1 Since June I have been free of pain and I have lots of energy again!
2 Only sexuality is now the problem. My boyfriend and I have not had
3 sexual intercourse yet. I feel like I am not yet ready for it.
4 Both mentally and physically.
5 In the hospital they say that I should not wait too long for it and
6 that at some point I should cross over that 'threshold'. Totally
7 agree! But is it taking too long now, I wonder?
8 [lines omitted]
9 I have a very sweet boyfriend who does give me time, but his
10 patience will of course run out eventually! I do not want to let it
11 get that far. Besides, I would WANT to start with it again as soon as
12 possible, but my mind's not really up for it. I would like to hear
13 about your experiences!

Anna presents her sexual problem as the predominant and only problem ("*only* sexuality is now *the* problem") and subsequently further explains this problem: She and her boyfriend "have not had sexual intercourse *yet*." Thus, she implicates there is a chance they will have intercourse in the future. By also presenting not having intercourse as a problem, which presupposes needing a solution, Anna implicates that they should have intercourse again. Moreover, she accounts for not having sexual intercourse: She is "not yet ready for it." So, by treating this as something that needs an explanation, we see Anna orienting to the norm that untroubled sex is part of a couple's relationship.

Additionally, it is implicated that the hospital sees having sexual intercourse as normative behaviour, as "they say" Anna should not wait too long for "it," and she should cross over "that threshold." As consensus (Potter, 1996) is provided, this claim is presented as if all HCPs in the hospital are in agreement, which builds up its factuality. Subsequently (lines 6-7), Anna implicates "totally" agreeing with this claim. However, she suggests it might be taking "too long now," by which she shows a presumption relating to how long it should take for cancer patients to start with intercourse again after treatment, and simultaneously presents this situation (not having intercourse with her boyfriend) as atypical. Again, this shows an orientation to the norm that sex is an essential piece of a partnered relationship.

Note that Anna's account for not having intercourse ("I am not yet ready for it") is introduced with "*I feel like*" (line 3). Compare this, for instance, with "I am not yet ready for it." Including "I feel like", makes her account less certain, suggesting that she cannot really put her finger on it. Anna's account also includes a mental state avowal ("want" in "I would *WANT* to start with it again") (Edwards & Potter, 2005) that is contrasted with Anna's "mind" not being up for it (see lines 11-12). In doing so, Anna orients to the impossibility of having sexual intercourse. She thereby anticipates the interactional concern of being someone who is not willing to have sex. Anna also externalises responsibility (Woolgar, 1988) for not having

intercourse by ascribing agency to her mind ("*my mind*'s not really up for it"). In this way, she creates *out-there-ness* (Potter, 1996): She suggests that her mind is in control. By stressing her willingness to have sex, Anna again orients to the norm that sex is part of an intimate relationship.

In addition, by saying her mind is "*not really*" up for it, Anna subtly displays doubt exactly at a point where there might be a dilemma (see Stake and Subtlety in Potter, 1996). Hereby, she implicates having difficulty pinpointing precisely what is going on, suggesting her issues are beyond her explanation. Moreover, by ascribing agency to her mind, she minimises her accountability for these issues. In effect, we see her dealing with an interactional dilemma: discussing her sexual issues without getting accused of these issues being a result of a personal shortcoming. Interestingly, this is what she is being called out on by the next participant (Kate):

Extract 1b (from Kate)

1 Problems with sexuality after gynaecological cancer are very
2 common. You will, indeed, have to cross over a threshold.
3 Now really ask yourself why your mind's not up for it.
4 Your boyfriend will have to take it easy and what is very important
5 use plenty of silicon-based lubricant.
6 [lines omitted]

In lines 1 and 2, Kate normalises Anna's problem by implicating that people commonly experience problems with sexuality after gynaecological cancer. She strengthens this claim by using a maximisation ("*very*"), commonly employed for emphasis (Potter, 1996). While it was first still negotiable, in extract 1b (line 2), Kate suggests that Anna "*indeed*" has "to cross over a threshold," affirming the normative expectation that intercourse should happen. With this, Kate is holding Anna responsible for acting on the norm that sex is part of a couple's relationship.

Additionally, although Anna minimised her accountability for the sexual issue, in line 3, Kate instructs Anna to "*really ask*" herself why her "mind's not up for *it*" (sexual intercourse), suggesting that Anna must know the answer to this question, and that she does play a role in this problem. Again, Anna is being held responsible, and this participant (Kate) also orients to the norm that sex is part of a couple's relationship. Otherwise, one could also pose the question of what other sexual activities Anna could try. The orientation to this norm is seen in line 4 and 5 as well, as Kate gives advice pertaining to the use of lubricant, implicating intercourse is going to happen again.

In the next extract, we show that this patient (Erin) also orients to this norm, now by explicitly contrasting her previous sex life with her partner with their sex life now:

Extract 2 (from Erin)

1 [lines omitted]
2 To keep to the impairments concerning this subject. My husband and I
3 were always 'normally' active with sex a couple of times a week.
4 Naturally, we slowly drifted into it, that it didn't work for me
5 anymore, simply because my mobility kept on decreasing. And however
6 you want to have sex, you still need to be a little mobile. I think…. (oops…).
7 Moreover, obviously with my cancer the pain became unbearable little
8 by little, which isn't exactly sex-promoting. But both of us also not
9 in the mood or it did not work. Did try though, almost up until 'the

10 end'. It took me many months to make a little bit of progress again.
11 [lines omitted]

In lines 2 and 3, Erin presents her sex life before having cancer as normal: She and her husband "were always *normally* active." By employing an extreme case formulation (Pomerantz, 1986), this is presented as if this was "*always*" the normal course of events. Hereby, Erin constructs having sex "a couple of times a week" as normal sexual behaviour, by which she shows an orientation to the norm that untroubled sex is part of a romantic relationship.

Next, Erin contrasts this previously normal situation with her sex life now, presenting the sexual issues as deviating from that normal situation. She constructs their sex life now as a process over which she and her husband have had no control, as she says it went "*naturally*" and they "*drifted into it*," by which she implicates it happened by chance. Moreover, Erin ascribes "that it didn't work… anymore" to her mobility that kept decreasing (lines 4-5), and again accounts for her sexual issues by attributing these to "the pain" caused by the cancer (lines 7-8). These accounts are additionally presented as self-evident ("simply because" and "obviously"), thereby increasing their credibility. With all this, Erin accounts for breaching the norm (untroubled sex is part of a couple's relationship) as to minimise the accountability of her partner as well as her own.

In addition, by saying "*however you want to* have sex," Erin accounts for deviating from the norm of having untroubled sex being an integral component of an intimate relationship by suggesting physical impairments are restraining her in having sex. While implicating she might want to have sex, her "mobility kept on decreasing". She even suggests that her pain became "unbearable." Thus, by presenting herself as a person who is willing to have sex, and by using the generic second-person pronoun "you," through which usage she minimises agency, she minimises her accountability for the sexual issues once more.

In lines 8, 9 and 10, it is suggested that, despite not being in the mood for "it," Erin and her husband kept on trying. Although Erin does not explicate what trying almost up until "the end" entails, it suggests they could not have tried harder. Hereby, she minimises her own accountability for not finding a solution to the issues. Moreover, by implicating a normative expectation that you should do something about your sexual issues (i.e., "it" not working), she again attends to the norm that sex is part of a romantic relationship.

In summary, patients put effort into minimising their accountability for the sexual issues and simultaneously present these issues as deviating from the previous situation. With this, patients treat these issues as something that needs to be accounted for, thus showing an orientation to the norm of having untroubled sex being part of an intimate relationship.

Next, extract 3a and 3b serve to show that, in treating their sexual issues as accountable, these patients also orient to the norm that untroubled sex is an essential piece of a couple's relationship. These extracts were written in response to each other (extract 3b was posted directly after extract 3a). Extract 3b is designed as a *second story* (Sacks, 1995): a response to a first story in which participants show alignment and identification with the teller of the first story.

Extract 3a (from Emily)

After 2 operations because of ovarian cancer I am definitely less in the mood for sex.
[lines omitted]
Also, getting aroused requires much more time. This is partly due to hormones that I do not produce anymore, partly due to the operations as well.
[lines omitted]
It isn't nice for him that I am never in the mood. I only feel like having sex when we have been into it for about 10 minutes.
And there is no fun in that.
I feel I'm fortunate to have a boyfriend who takes all the time in the world for it. He doesn't (and I'm exaggerating) really mind, because sex lasts longer now.
[lines omitted]

Extract 3b (from Jean)

Hello Emily
[lines omitted]
After my last operation that I had in July my mood for making love with my husband has dropped to zero. (even below zero)
I enjoy the cuddling and the attention from my husband, and he is fortunately very patient, and before cervical cancer came into our life we had been having a very busy sex life so to speak!
The shock is even more for me than for my husband that after the last operation I do not want any sex anymore!!
The rest yes cuddling kissing etc but the rest 🙂🙂
Look, we are doing it, but I do not enjoy it at all, but that is absolutely not my husband's doing. Do you maybe have a tip for me so I can enjoy it more
[lines omitted]
love, Jean

As Jean raises the same topic, designed in a similar way as Emily's introduction (extract 3a), Jean's reference to her last surgery (line 3) works as an entry device to introduce her own story. In second stories, participants often show a selective focus on a previous story (Arminen, 2004). Here, the focus lies on attributing the sexual issues to external factors: "my last operation" (extract 3b, line 3) and "cervical cancer" (extract 3b, line 6). Additionally, in extract 3a, Emily externalises the activity of getting aroused ("*the* getting aroused"), thereby drawing emphasis away from herself as the actor (Potter, 1996). So, both Emily and Jean downplay accountability for their sexual issues, thus fending off the impression that these issues are a result of a personal shortcoming.

In both descriptions, maximisations (Potter, 1996) are used that emphasise the contrast between the situation before and after cancer. See, for instance, lines 1, 2 and 4 in extract 3a, in which Emily suggests being "*definitely less*" in the mood for sex and that getting aroused requires "*much more*" time. Also, Jean's account (in extract 3b) that her mood for making love has dropped is bolstered by stressing that it has dropped "*even below zero*" (see line 4). By

doing so, she implicates her mood could not be less, and simultaneously presents this as a major change.

Thus, as their sex life now is presented as a deviation from their usual sexual behaviour, Emily and Jean fend off not enjoying intimate and sexual activities as a dispositional treat: It is not something that is inherent to them as a person (Edwards, 2005). This is consistent with previous discursive psychological research (Horton-Salway, 2001), which demonstrated, in the context of physical activity, that patients used a before and after story to present themselves as previously tremendously active, countering the potential inference of them being the type to enjoy a sedentary lifestyle.

In extract 3b, Jean additionally bolsters her account by suggesting that she and her husband "had been having a *very* busy sex life." Moreover, she shows it was a shock to her, not wanting any sex anymore (see lines 8-9), suggesting this sexual issue has come over them by no fault of their own. Hereby, she strengthens the claim that she, and now her partner as well, are not to blame for the sexual issues. So, by treating these issues (e.g., never being in the mood) as accountable, both patients orient to the norm that untroubled sex is part of a romantic relationship.

They also orient to this norm by implicating they are still engaged in sexual activities despite, for instance, suggesting not enjoying it "*at all*" (see extract 3b, line 11). In lines 8-13 of extract 3a, Emily orients to this norm again. She does so, first by presenting needing an incentive in order to get in the mood as deviant ("I *only* feel like having sex when we have been into it for about 10 minutes"). She, thereby, suggests that it takes too long before she feels like having sex. Furthermore, although Emily repeatedly describes herself as being never or less in the mood, she implicates that she and her boyfriend are still having sex. She, thus, treats having sex as a normative expectation.

Finally, Jean implicates wanting some intimate activities ("cuddling kissing"), but not wanting to do "the rest", and asks Emily how to enjoy "it" more. Although we can cautiously assume that "it" refers to "sex" (see line 9, extract 3b), it is left up to the readers of the post to draw their own conclusions. This enables Jean to avoid explicating the type of sexual activity. As second stories are relevant for interpreting a first story (Arminen, 2004), in asking for advice on how to enjoy "it" more, Jean displays her understanding of Emily's experience in which Emily described being less in the mood. Jean treats this experience as an indication Emily still can enjoy sex, and by asking advice, she orients to the accountability of doing something about the sexual issues.

Additionally, these patients present the way their male partners deal with the sexual issues as something fortunate (see, for instance, extract 3a, line 11). In the next paragraph, we will discuss this further by using illustrative examples of how female patients bring their male partners into the discussion.

Norm 2: Male Partner Is Entitled to Having Untroubled Sex

We will now focus on the second norm female patients orient to when discussing their sexual issues: Male partners being entitled to untroubled sex. As could already be seen in the previous extracts, women orient to this norm, for instance, by portraying their partners as very patient (extract 3b, lines 5-6) and simultaneously suggesting they are the ones affected by the sexual issues (extract 3a, line 8). Now, we will show how Anna orients to this norm. Note that this extract (4a) is a representation of the second part of extract 1a.

Extract 4a (from Anna)

[lines omitted]
I have a very sweet boyfriend who does give me time, but his patience will of course run out eventually! I do not want to let it get that far. Besides, I would WANT to start with it again as soon as possible, but my mind's not really up for it. I would like to hear about your experiences!

By demonstrating that her boyfriend is giving her time, but that his patience is finite (lines 9-10), Anna portrays him as someone who is affected by an unsustainable situation. Moreover, Anna implicates wanting to deal with the problem for the sake of her boyfriend, since she suggests not wanting it to get to the point where "*his* patience" runs out (lines 9-11). With this, she deals with the interactional concern of not taking the needs of her partner into account. She furthermore stresses that "his patience will *of course* run out eventually!", presenting this as self-evident (Potter, 1996). Overall, her boyfriend's patience running out is presented as causing this situation to be problematic, by which Anna orients to the norm that male partners are entitled to untroubled sex.

However, Anna accounts for her boyfriend's way of dealing with the current situation by emphasising that her boyfriend is very sweet, gives her time, and has patience. In doing so, she wards off the impression that her boyfriend is pressuring her or is complaining about the situation. This claim is strengthened by a maximisation ("*very* sweet"). Hereby, Anna simultaneously anticipates the interactional dilemma of discussing her sexual issues without implicating her partner as the cause of these issues or as the cause of discussing these issues.

Next, we show Kate's response:

Extract 4b (from Kate)

[lines omitted]
Your boyfriend will have to take it easy and what is very important use plenty of silicon-based lubricant.
[lines omitted]

In extract 4a, Anna portrayed her boyfriend as someone who is affected by her sexual issues. Interestingly, Kate makes relevant Anna's partner by telling what he should do: He "will have to take it easy." Now, in addition to what we presented in extract 1b, not only Anna but also her boyfriend is made responsible: He is being called on having a more active role to play in dealing with the sexual issues. This suggests the male partner must work for what he might be entitled to.

The following extract is part of a thread that was initially about problems with sexuality in relation to brain tumours. In response to the first post, Olivia shows that these problems also arise in other cancer types. By simultaneously presenting herself as someone with a different type of cancer (tongue cancer), she achieves membership to the same category as the patient who wrote the first post: cancer patients. Hereby, she establishes the entitlement to talk about her experiences (Whalen & Zimmerman, 1990):

Extract 5 (from Olivia)

In my opinion this is a subject that goes for many cancer types.
I had tongue cancer. I've been cured since a couple of months but the
treatment has caused great damage. My sexual relationship with
my partner had always been fantastic. There is nothing left of that
anymore. I am not in the mood anymore, I do not feel the arousal
anymore. We still make love, we stay intimate but the intense
excitement is gone. It seems like I have lost that emotion. I hope
that it will return. My husband is very understanding fortunately,
we talk about it a lot and I ask him to also have patience here. I do
miss it but the feeling is gone.

In lines 3 and 4, Olivia introduces her partner ("my sexual relationship with my partner") as part of creating an extreme contrast between their sex life before ("had *always* been *fantastic*") and after cancer treatment ("*nothing* left of that *anymore*"). Meanwhile, she presents her sexual relationship as one in which intimacy is still a component (see line 6). All this works to both fend off not enjoying intimate and sexual activities being seen as a dispositional trait (Edwards, 2005) and also to minimise her partner's accountability for the sexual issues. As is consistent with previous work by Smith (1990), these contrast structures in extracts 2, 3a, 3b, and 5 create a tension between two extremes and are used to present the sexual issues as deviating from the situation before cancer: having a very busy (extract 3b) or fantastic sex life (this extract) together with their partner.

In lines 8, 9 and 10, Olivia mentions that her husband is "*very*" understanding, that they talk about it "*a lot*," and that she asks him to have patience. With these maximisations, she strengthens the suggestion that her husband is not pressuring her, and simultaneously counters any implication of her husband being the cause of these issues or the cause of discussing these issues. Furthermore, she presents her husband's way of dealing with the situation as something to be fortunate about. Also note that asking for patience implies that her husband is affected by this problem, but also that change will eventually occur. In this way, Olivia orients to both norms that patients in this study orient to: Having untroubled sex is an integral component of a couple's relationship, and the male partner is entitled to having untroubled sex.

This extract again shows a patient putting effort into minimising accountability for her sexual issues. This is done by Olivia, for instance, by constructing the "intense excitement" as something that exists through actions that are beyond her control (see lines 6-8: "the intense excitement *is gone*," and "hope that *it will return*"). Additionally, by using the mental state avowal "hope" (Edwards & Potter, 2005), it is implicated that the return of the "intense excitement" is independent of her own influence on this. Moreover, by saying that "*it seems like*" she has lost "that emotion," she displays doubt, suggesting that the sexual issues are beyond her explanation. By doing this and by constructing out-there-ness, Olivia minimises accountability for these issues.

To summarise, the figure below illustrates the interactional concerns that were managed through female patients' interactional practices, and the interrelated norms that these women oriented to.

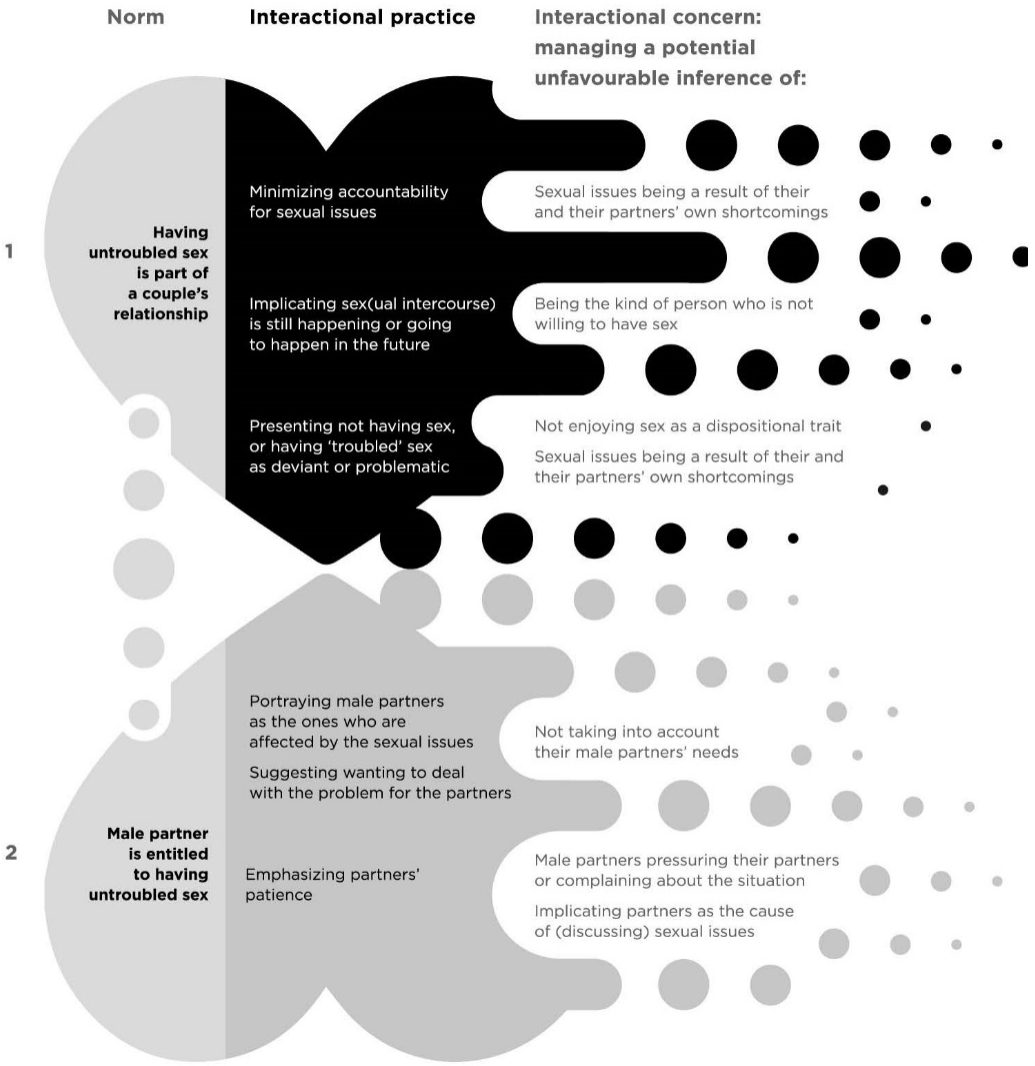

Figure 1. Overview of Norms, Interactional Practices, and Interactional Concerns

Discussion

Our analysis fills a gap in research by demonstrating how women describe their experiences with sexuality during and after cancer through their own words. Furthermore, our findings offer relevant opportunities for engaging in conversations about sexuality with women with cancer and their partners. We would recommend taking into account that female patients often refer to their partners when discussing sexual issues and present these issues as something that affects their partner. While it has been suggested that open and constructive communication can help in adjusting to cancer-related issues (Milbury & Badr, 2013), previous research has shown that couples dealing with cancer do not always talk about the effect of cancer on sexuality (Lindau et al., 2011). So, since patients in our study frequently stress their partners' role in their sexual issues, it could be beneficial for HCPs to recommend patients to engage or continue to engage in open communication with their partners.

We found that female patients orient to two norms: (1) Having untroubled sex is part of a couple's relationship, and (2) the male partner is entitled to having untroubled sex. These

findings are consistent with a study about the experiences of women with vulval pain (Marriott & Thompson, 2008) in which women reported to perceive sexual intercourse as key both to a good heterosexual relationship and to their female role. In addition, sex was described as something other healthy women find easy and natural. Similarly, in our study, patients orient to untroubled sex as the norm and construct deviations as accountable. Although it is plausible that norms can have an influence on patients' behaviours, our discursive psychological analysis does not allow us to draw any conclusions in this respect. However, these norms may limit the scope of tools women can use to talk about their issues.

Although occasionally it remains implicit what patients in our study refer to with "sex," the term "sexual intercourse" was used in extract 1a and advice was given about using "silicon-based lubricant" (see extract 1b), implicating a focus on intercourse. Additionally, talking about not wanting "any sex anymore" (extract 3b), suggests this also includes sexual intercourse. So, when patients in our study suggest that they keep on having sex, while also implicating that they are not in the mood (see for example lines 1-2 in extract 3a), this indicates an adherence to the coital imperative, positioning penile-vaginal intercourse as real or normal sex (Braun et al., 2003).

Female patients treating penile-vaginal intercourse as a preferred form of sexual behaviour could have an adverse effect on the chances of heterosexual women for sexual pleasure (Laan et al., 2021). This is particularly true for cervical cancer survivors, since they often experience pain during intercourse (Carr, 2015). In OHCs, moderators and/or HCPs could address the coital imperative by making other norms relevant in information or in patients' stories for instance. Considering that euphemistic language and misinformation can negatively affect people's interactions and behaviours (Lucas & Fyke, 2014; Pan et al., 2021), attention must then also be paid to the correctness of information in general, and the correctness of terms for body parts and sexual activities in particular. Research has shown that OHC members are rather capable of detecting and dealing with inaccurate information (Loane & D'Alessandro, 2013). However, recognising the implicit norms people orient to poses a more challenging issue. In medical consultations, HCPs could also discuss the norms that patients in our study orient to.

HCPs can, for example, discuss the norm that having sex is part of a couple's relationship in an effort to renegotiate the coital imperative. This could be of help when supporting cancer patients in exploring alternative sexual activities. Additionally, this could involve taking into account the norm that portrays male partners as being entitled to having untroubled sex. This finding touches upon the fact that, in present-day society, heterosexual women's sexual pleasure is continuously treated as mostly secondary to that of heterosexual men (Hall, 2019). Bringing this norm up for discussion might be beneficial to women's own pleasurable sexual experiences.

Previous research has shown that, when health professionals do discuss sexuality with cancer patients, the focus lies mainly on the biomedical aspects (O'Connor et al., 2019). Incorporating the abovementioned suggestions in oncological practice might require HCPs to adopt a biopsychological approach in discussing sexuality with their patients. Such an approach takes into account biological, psychological, sociocultural, and interpersonal factors when discussing and treating sexual issues (Bober & Varela, 2012). Overall, it is essential for HCPs to learn and employ interactional practices that establish an environment in which patients' own sexual pleasure is prioritised and the absence of coital sex could also be normal and acceptable.

Additionally, in line with a study in which patients' illness narratives were characterised by talking about a life before and after cancer (Chou et al., 2011), in our study, female patients contrast their previous sexually active life with a troubled sex life. By doing so, they present their sexual issues as deviating from the previous situation, and simultaneously anticipate any inference of these issues as being indicative of their character (i.e., not enjoying sex as a dispositional trait). Furthermore, as is consistent with other discursive psychological research (de Kok & Widdicombe, 2008; Guise et al., 2007), patients attribute their issues to external factors. In doing so, women with cancer counter the claim that their sexual issues are a result of their own or their partners' shortcomings, thus minimising the accountability of both. So, when broaching the topic of sexuality, professionals could align with what cancer patients in our study make relevant. For instance, by emphasising that it is indeed very common to experience sexual problems, such as reduced arousal, or that it is actually perfectly normal to need an incentive to become aroused (see extract 3a). By stressing that patients are not accountable for the occurrence of sexual issues, these issues can be normalised, and patients will find an answer to the question: "Are my sexual problems normal?" (Albers et al., 2020; Hordern & Street, 2007).

Incorporating changes in OHCs could be another useful intervention. OHCs could create a place for patients to ask questions directly to HCPs and involve sexologists to answer questions (some platforms have already begun to do so). Furthermore, these communities could make patients' stories available, and suggest ways to deal with sexual issues that foreground women's sexual pleasure and other sexual activities that are different from penile-vaginal intercourse.

Future research can build on this current exploratory study and could additionally focus on its limitations. Although our study has uncovered norms that patients orient to when accounting for their sexual issues, we only focused on posts in which participants describe themselves as women in a heterosexual relationship. It follows that we did not include posts in which participants present themselves as male or as members of the LGBTQ+ community. This limits our ability to generalise findings or to draw comparisons between different population groups. Further research should focus on these forum participants as well in order to gain a deeper understanding of social practices and their effects within talk about cancer and sexual health.

Conclusion

Our analysis showed that women with cancer treat their sexual issues, and their way of dealing with these issues, as accountable. They described their sexual issues in such a way (e.g., minimising accountability for the issues and creating an extreme contrast between their previous sex life and their sex life now) that displayed the issues' status with regard to a norm: the norm that having untroubled sex is part of a couple's relationship. Furthermore, the analysis brought to light an orientation to a second norm. By suggesting that their male partners are affected by their sexual issues, women with cancer displayed an orientation to the norm that male partners are entitled to having untroubled sex. However, patients implicated that their male partners do not insist on this right. They are actually portrayed as being very considerate, which works to avoid the potential accusation of implicating partners as the cause of the sexual issues, or as the reason for discussing these issues in the first place. When talking about sexuality with people dealing with cancer, HCPs can make these norms explicit and, in doing

so, explore alternative sexual activities that are beneficial to women's own sexual health. Moreover, our findings can help HCPs and OHCs in aligning with cancer patients' interactional concerns in order to discuss and present sexuality in a way that contributes to normalising patients' sexual issues.

Notes

1. The remaining posts from one of the three forums turned out to be almost exclusively related to the fear of having cancer, though in combination with sexual activities. Therefore, this inconsequential and small number of posts were excluded from the dataset.
2. Hereinafter, we refer to these participants as 'women with cancer', 'patients', or 'female patients'.
3. Additional agreements were made with the administrator of one of the three forums pertaining to consent from forum users being required for publication of their posts.
4. Some parts of the extracts that are not relevant to the analysis were omitted.

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Conflict of Interest

We declare that we do not have any conflicts of interest.

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Ethical Approval

According to Dutch legislation, ethical approval by a medical ethics committee was not required for this study because research participants were not subjected to procedures or required to follow rules of behaviour.

References

Albers, L. F., van Belzen, M. A., van Batenburg, C., Engelen, V., Putter, H., Pelger, R. C. M., & Elzevier, H. W. (2020). Discussing sexuality in cancer care: towards personalized information for cancer patients and survivors. *Supportive Care in Cancer*, *28*(9), 4227–4233. https://doi.org/10.1007/s00520-019-05257-3

Antaki, C., Ardevol, E., Nunez, F., & Vayreda, A. (2005). "For she who knows who she is:" Managing Accountability in Online Forum Messages. *Journal of Computer-Mediated Communication*, *11*(1), 114–132. https://doi.org/10.1111/j.1083-6101.2006.tb00306.x

Arminen, I. (2004). Second stories: The salience of interpersonal communication for mutual help in Alcoholics Anonymous. *Journal of Pragmatics*, *36*(2), 319–347. https://doi.org/10.1016/j.pragma.2003.07.001

Basinger, E. D., Delaney, A. L., & Williams, C. (2021). Uncertainty Management in Online Sexual Health Forums. *Health Communication*, 1–10. https://doi.org/10.1080/10410236.2021.1980253

Blank, T. O., & Adams-Blodnieks, M. (2007). The who and the what of usage of two cancer online communities. *Computers in Human Behavior*, *23*(3), 1249–1257. https://doi.org/10.1016/j.chb.2004.12.003

Bober, S. L., & Varela, V. S. (2012). Sexuality in Adult Cancer Survivors: Challenges and Intervention. *Journal of Clinical Oncology*, *30*(30), 3712–3719. https://doi.org/10.1200/JCO.2012.41.7915

Braun, V., Gavey, N., & McPhillips, K. (2003). The `Fair Deal'? Unpacking Accounts of Reciprocity in Heterosex. *Sexualities*, *6*(2), 237–261. https://doi.org/10.1177/1363460703006002005

Carr, S. V. (2015). Psychosexual health in gynecological cancer. *International Journal of Gynecology & Obstetrics*, *131*(S2), S159–S163. https://doi.org/10.1016/j.ijgo.2015.06.014

Chou, W.-Y. S., Hunt, Y., Folkers, A., & Augustson, E. (2011). Cancer Survivorship in the Age of YouTube and Social Media: A Narrative Analysis. *Journal of Medical Internet Research*, *13*(1). https://doi.org/10.2196/jmir.1569

Cleary, V., & Hegarty, J. (2011). Understanding sexuality in women with gynaecological cancer. *European Journal of Oncology Nursing*, *15*(1), 38–45. https://doi.org/10.1016/j.ejon.2010.05.008

Davison, K. P., Pennebaker, J. W., & Dickerson, S. S. (2000). Who talks? The social psychology of illness support groups. *American Psychologist*, *55*(2), 205–217. https://doi.org/10.1037/0003-066X.55.2.205

de Kok, B. C., & Widdicombe, S. (2008). 'I really tried': Management of normative issues in accounts of responses to infertility. *Social Science & Medicine*, *67*(7), 1083–1093. https://doi.org/10.1016/j.socscimed.2008.05.007

de Vocht, H. (2011). A team approach towards communication about sexuality and intimacy in cancer and palliative care. study. *Australasian Medical Journal*, *4*(11), 610–619. https://doi.org/10.4066/AMJ.2011.1047

Ditchfield, H. (2021). Ethical Challenges in Collecting and Analysing Online Interactions. In J. Meredith, D. Giles, & W. Stommel (Eds.), *Analysing Digital Interaction. Palgrave Studies in Discursive psychology* (pp. 23–40). Palgrave Macmillan. https://doi.org/10.1007/978-3-030-64922-7_2

Edwards, D. (1997). *Discourse and Cognition*. SAGE.

Edwards, D. (2005). Moaning, whinging and laughing: the subjective side of complaints. *Discourse Studies*, *7*(1), 5–29. https://doi.org/10.1177/1461445605048765

Edwards, D., & Potter, J. (1992). *Discursive Psychology*. SAGE.

Edwards, D., & Potter, J. (2005). Discursive psychology, mental states and descriptions. In H. Te Molder, & J. Potter (Eds.), *Conversation and Cognition* (pp. 241–259). Cambridge University Press. https://doi.org/10.1017/CBO9780511489990.012

European Cancer Information System. (n.d.). *Estimates of cancer incidence and mortality in 2020, for all countries*. Retrieved February 16, 2022, from https://ecis.jrc.ec.europa.eu

Flinkfeldt, M. (2011). 'Filling one's days': managing sick leave legitimacy in an online forum. *Sociology of Health & Illness*, *33*(5), 761–776. https://doi.org/10.1111/j.1467-9566.2011.01330.x

Foster, C., Calman, L., Richardson, A., Pimperton, H., & Nash, R. (2018). Improving the lives of people living with and beyond cancer: Generating the evidence needed to inform policy and practice. *Journal of Cancer Policy*, *15*(B), 92–95. https://doi.org/10.1016/j.jcpo.2018.02.004

Gilbert, E., Perz, J., & Ussher, J. M. (2016). Talking about sex with health professionals: the experience of people with cancer and their partners. *European Journal of Cancer Care*, *25*(2), 280–293. https://doi.org/10.1111/ecc.12216

Guise, J., Widdicombe, S., & McKinlay, A. (2007). 'What is it like to have ME?': The discursive construction of ME in computer-mediated communication and face-to-face interaction. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *11*(1), 87–108. https://doi.org/10.1177/1363459307070806

Hall, K. S. K. (2019). Cultural Differences in the Treatment of Sex Problems. *Current Sexual Health Reports*, *11*(1), 29–34. https://doi.org/10.1007/s11930-019-00189-9

Hepburn, A., & Potter, J. (2003). Discourse Analytic Practice. In C. Seale, G. Gobo, J. F. Gubrium, & D. Silverman (Eds.), *Qualitative Research Practice* (pp. 180–196). SAGE Publications Ltd. https://doi.org/10.4135/9781848608191

Hordern, A. J., & Street, A. F. (2007). Communicating about patient sexuality and intimacy after cancer: mismatched expectations and unmet needs. *Medical Journal of Australia*, *186*(5), 224–227. https://doi.org/10.5694/j.1326-5377.2007.tb00877.x

Horton-Salway, M. (2001). Narrative Identities and the Management of Personal Accountability in Talk about ME: A Discursive Psychology Approach to Illness Narrative. *Journal of Health Psychology*, *6*(2), 247–259. https://doi.org/10.1177/135910530100600210

Johnston, A. C., Worrell, J. L., Di Gangi, P. M., & Wasko, M. (2013). Online health communities. *Information Technology & People*, *26*(2), 213–235. https://doi.org/10.1108/ITP-02-2013-0040

Kaal, S. E. J., Husson, O., van Dartel, F., Hermans, K., Jansen, R., Manten-Horst, E., Servaes, P., van de Belt, T., Engelen, L. J. L. P. G., Prins, J. B., Verberne, S., & van der Graaf, W. T. (2018). Online support community for adolescents and young adults (AYAs) with cancer: user statistics, evaluation, and content analysis. *Patient Preference and Adherence*, *12*, 2615–2622. https://doi.org/10.2147/PPA.S171892

Kanker.nl (n.d.). *Over ons.* Retrieved February 23, 2023, from https://www.kanker.nl/overig/over-ons

Keim-Malpass, J., Baernholdt, M., Erickson, J. M., Ropka, M. E., Schroen, A. T., & Steeves, R. H. (2013). Blogging Through Cancer. *Cancer Nursing*, *36*(2), 163–172. https://doi.org/10.1097/NCC.0b013e31824eb879

Kiyimba, N., Lester, J. N., & O'Reilly, M. (2019). *Using Naturally Occurring Data in Qualitative Health Research*. Springer International Publishing. https://doi.org/10.1007/978-3-319-94839-3

Krouwel, E. M., Nicolai, M. P. J., van Steijn-van Tol, A. Q. M. J., Putter, H., Osanto, S., Pelger, R. C. M., & Elzevier, H. W. (2015). Addressing changed sexual functioning in cancer patients: A cross-sectional survey among Dutch oncology nurses. *European Journal of Oncology Nursing*, *19*(6), 707–715. https://doi.org/10.1016/j.ejon.2015.05.005

Laan, E. T. M., Klein, V., Werner, M. A., van Lunsen, R. H. W., & Janssen, E. (2021). In Pursuit of Pleasure: A Biopsychosocial Perspective on Sexual Pleasure and Gender. *International Journal of Sexual Health*, 1–21. https://doi.org/10.1080/19317611.2021.1965689

Lamerichs, J., Koelen, M., & te Molder, H. (2009). Turning Adolescents Into Analysts of Their Own Discourse: Raising Reflexive Awareness of Everyday Talk to Develop Peer-Based Health Activities. *Qualitative Health Research*, *19*(8), 1162–1175. https://doi.org/10.1177/1049732309341655

Lamerichs, J., & van Hooijdonk, C. (2019). "Mijn stoma is een #superstoma": Een discursieve analyse van blogs over stoma's. *Tijdschrift Voor Taalbeheersing*, *41*(3), 461–484. https://doi.org/10.5117/TVT2019.3.003.LAME

Lang-Rollin, I., & Berberich, G. (2018). Psycho-oncology. *Dialogues in Clinical Neuroscience*, *20*(1), 13–22. https://doi.org/10.31887/DCNS.2018.20.1/ilangrollin

Lindau, S. T., Surawska, H., Paice, J., & Baron, S. R. (2011). Communication about sexuality and intimacy in couples affected by lung cancer and their clinical-care providers. *Psycho-Oncology*, *20*(2), 179–185. https://doi.org/10.1002/pon.1787

Loane, S. S., & D'Alessandro, S. (2013). Communication That Changes Lives: Social Support Within an Online Health Community for ALS. *Communication Quarterly*, *61*(2), 236–251. https://doi.org/10.1080/01463373.2012.752397

Lucas, K., & Fyke, J. P. (2014). Euphemisms and Ethics: A Language-Centered Analysis of Penn State's Sexual Abuse Scandal. *Journal of Business Ethics*, *122*(4), 551–569. https://doi.org/10.1007/s10551-013-1777-0

Marriott, C., & Thompson, A. R. (2008). Managing threats to femininity: Personal and interpersonal experience of living with vulval pain. *Psychology & Health*, *23*(2), 243–258. https://doi.org/10.1080/14768320601168185

Mercadante, S., Vitrano, V., & Catania, V. (2010). Sexual issues in early and late stage cancer: a review. *Supportive Care in Cancer*, *18*(6), 659–665. https://doi.org/10.1007/s00520-010-0814-0

Milbury, K., & Badr, H. (2013). Sexual problems, communication patterns, and depressive symptoms in couples coping with metastatic breast cancer. *Psycho-Oncology*, *22*(4), 814–822. https://doi.org/10.1002/pon.3079

O'Connor, S. R., Connaghan, J., Maguire, R., Kotronoulas, G., Flannagan, C., Jain, S., Brady, N., & McCaughan, E. (2019). Healthcare professional perceived barriers and facilitators to discussing sexual wellbeing with patients after diagnosis of chronic illness: A mixed-methods evidence synthesis. *Patient Education and Counseling*, *102*(5), 850–863. https://doi.org/10.1016/j.pec.2018.12.015

Osei, D. K., Lee, J. W., Modest, N. N., & Pothier, P. K. T. (2013). Effects of an Online Support Group for Prostate Cancer Survivors: A Randomized Trial. *Urologic Nursing*, *33*(3), 123. https://doi.org/10.7257/1053-816X.2013.33.3.123

Pan, W., Liu, D., & Fang, J. (2021). An Examination of Factors Contributing to the Acceptance of Online Health Misinformation. *Frontiers in Psychology*, *12*, 1–11. https://doi.org/10.3389/fpsyg.2021.630268

Pomerantz, A. (1986). Extreme case formulations: A way of legitimizing claims. *Human Studies*, *9*(2–3), 219–229. https://doi.org/10.1007/BF00148128

Potter, J. (1996). *Representing Reality: Discourse, Rhetoric and Social Construction*. SAGE.

Potter, J. (2012). Discourse Analysis and Discursive Psychology. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in Psychology: Vol. 2. Research Designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 119–138). American Psychological Association. https://doi.org/10.1037/13620-008

Ratner, E. S., Foran, K. A., Schwartz, P. E., & Minkin, M. J. (2010). Sexuality and intimacy after gynecological cancer. *Maturitas*, *66*(1), 23–26. https://doi.org/10.1016/j.maturitas.2010.01.015

Robinson, K. M. (2001). Unsolicited Narratives from the Internet: A Rich Source of Qualitative Data. *Qualitative Health Research*, *11*(5), 706–714. https://doi.org/10.1177/104973201129119398

Sacks, H. (1995). *Lectures on Conversation, Vol I & II*. Blackwell Publishing. https://doi.org/10.1002/9781444328301

Sadovsky, R., Basson, R., Krychman, M., Morales, A. M., Schover, L., Wang, R., & Incrocci, L. (2010). Cancer and Sexual Problems. *The Journal of Sexual Medicine*, *7*(1), 349–373. https://doi.org/10.1111/j.1743-6109.2009.01620.x

Smith, D. E. (1990). Texts, Facts and Femininity: Exploring the Relations of Ruling (1st ed.). Routledge. https://doi.org/10.4324/9780203425022

Sneijder, P., & te Molder, H. F. M. (2006). Disputing taste: food pleasure as an achievement in interaction. *Appetite*, *46*(1), 107–116. https://doi.org/10.1016/j.appet.2005.10.002

Stommel, W., & Koole, T. (2010). The online support group as a community: A micro-analysis of the interaction with a new member. *Discourse Studies*, *12*(3), 357–378. https://doi.org/10.1177/1461445609358518

Sung, H., Ferlay, J., Siegel, R. L., Laversanne, M., Soerjomataram, I., Jemal, A., & Bray, F. (2021). Global Cancer Statistics 2020: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries. *CA: A Cancer Journal for Clinicians*, *71*(3), 209–249. https://doi.org/10.3322/caac.21660

Tierney, D. K. (2008). Sexuality: A Quality-of-Life Issue for Cancer Survivors. *Seminars in Oncology Nursing*, *24*(2), 71–79. https://doi.org/10.1016/j.soncn.2008.02.001

Ussher, J. M., Perz, J., Gilbert, E., Wong, W. K. T., Mason, C., Hobbs, K., & Kirsten, L. (2013). Talking about sex after cancer: A discourse analytic study of health care professional accounts of sexual communication with patients. *Psychology & Health*, *28*(12), 1370–1390. https://doi.org/10.1080/08870446.2013.811242

Versteeg, W., te Molder, H., & Sneijder, P. (2018). "Listen to your body": Participants' alternative to science in online health discussions. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *22*(5), 432–450. https://doi.org/10.1177/1363459317695632

Whalen, M. R., & Zimmerman, D. H. (1990). Describing trouble: Practical epistemology in citizen calls to the police. *Language in Society*, *19*(4), 465–492. https://doi.org/10.1017/S0047404500014779

Wiggins, S. (2017). *Discursive Psychology: Theory, Method and Applications*. SAGE.

Wiggins, S., & Potter, J. (2008). Discursive psychology. In C. Willig, & W. Stainton-Rogers (Eds.), *SAGE Handbook of Qualitative Research in Psychology* (pp. 73–90). SAGE Publications Ltd. https://doi.org/10.4135/9781848607927

Wiljer, D., Urowitz, S., Barbera, L., Chivers, M. L., Quartey, N. K., Ferguson, S. E., To, M., & Classen, C. C. (2011). A Qualitative Study of an Internet-Based Support Group for Women with Sexual Distress Due to Gynecologic Cancer. *Journal of Cancer Education*, *26*(3), 451–458. https://doi.org/10.1007/s13187-011-0215-1

Woods, N. F. (1987). Toward a holistic perspective of human sexuality: Alterations in sexual health and nursing diagnoses. *Holistic Nursing Practice*, *1*(4), 1–11.

Woolgar, S. (1988). *Science: The Very Idea*. Travistock Publications.

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Annette Klarenbeek is as a professor of communication at the HU University of Applied Sciences Utrecht (The Netherlands). She obtained her PhD on crisis communication and focuses her research on the way people discuss societal issues and transitions, and its implications for the communication practice.

Tessa Roseboom is a professor of early development and health at the Faculty of Medicine of the University of Amsterdam (The Netherlands). Her academic research focuses on the effects of early-life environment on human growth, development, and health throughout life.

Ellen Laan was a professor of biopsychosocial determinants of sexual health at the Faculty of Medicine of the University of Amsterdam (The Netherlands). She obtained her PhD on research into sexuality perception among women and has published work on the mechanisms underlying sexual arousal. Ellen Laan passed away on 22 January 2022.