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A Qualitative Study on Barriers to Reintegrating into Family Life among Survivors of Uterine Cervical Neoplasms during the Extended Survival Meriod

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Abstract

Objective: Guided by Transitions Theory, this study aims to explore the lived experiences and barriers faced by survivors of Uterine Cervical Neoplasms as they reintegrate into family life during the Extended Survival Meriod. The findings provide a theoretical basis for developing targeted, family-based rehabilitation support programs. Methods: A descriptive phenomenological approach was employed. Using purposive sampling, semi-structured interviews were conducted with 11 patients with Uterine Cervical Neoplasms in the Extended Survival Meriod. Participants were recruited from the gynecological oncology center of a tertiary hospital between June and December 2025. Data were analyzed using Colaizzi's seven-step method, with coding facilitated by NVivo 12.0 software. Results: Three core themes and eleven subthemes emerged from the data: (1) Transition conditions (accepting an altered body image, reconstructing female identity, activating family emotional support, and acquiring sexual rehabilitation knowledge); (2) Transition barriers (the "freezing" of marital intimacy, frustration in fulfilling traditional "good wife and loving mother" roles, social stigma associated with lymphedema, and fear of cancer recurrence and abandonment); (3) Response patterns dyadic coping and communication attempts, solitary endurance, and seeking peer support and empathy. Conclusion: The reintegration of patients with Uterine Cervical Neoplasms into family life is a complex transitional process fraught with physical and psychological challenges. Healthcare providers should prioritize the dual reconstruction needs of patients' "family roles" and "female roles."

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By adopting perspectives centered on dyadic coping and family resilience, providers can deliver comprehensive support, including sexual health education and targeted family communication strategies.

Keywords

Uterine Cervical Neoplasms, Extended Survival Meriod, Qualitative Research, Transitions Theory

1. Introduction

According to the 2022 epidemiological analysis of malignant tumors in China, the incidence rate of Uterine Cervical Neoplasms remains the highest among malignant tumors of the female reproductive system [1]. With the popularization of screening and advancements in diagnostic and treatment technologies, the 5-year survival rate for patients with Uterine Cervical Neoplasms has significantly improved, transforming their survival trajectory into a chronic disease management process. The Extended Survival Meriod refers to the equilibrium phase following the completion of primary treatment (surgery/chemoradiotherapy), during which the body gradually recovers but has not yet fully returned to normal. This represents a critical window for patients transitioning from a "patient role" to a "social/family role."

However, existing research indicates that patients with Uterine Cervical Neoplasms face unique challenges during this period: sequelae such as lymphedema, premature ovarian failure, and sexual dysfunction severely impair their quality of life [2]. As the family serves as the core environment for patient rehabilitation, the restoration of family function is directly correlated with the quality of survival. Nevertheless, current domestic studies predominantly focus on physiological recovery or isolated psychological indicators. There is a notable lack of in-depth exploration, from the patients' subjective perspectives, of the deep-seated barriers (particularly regarding intimate relationships and role conflicts) they encounter when reintegrating into family life [3]. Meleis's Transitions Theory posits that a transition is a complex process individuals undergo during changes in life patterns; insufficient preparation and support can easily lead to an ineffective transition [4]. Consequently, guided by Transitions Theory, this study utilizes a phenomenological qualitative research approach to explore the actual barriers faced by Uterine Cervical Neoplasms Survivors when returning to family life, aiming to provide an empirical foundation for clinical nursing interventions.

2. Materials and Methods

2.1. Study Participants

A purposive sampling method, adhering to the principle of maximum variation, was employed to select patients with diverse ages, marital and childbearing statuses, treatment modalities, and family structures, thereby ensuring the representativeness of the sample and the richness of the data. Potential participants were identified by the clinical head nurse during routine follow-up appointments. The primary investigator subsequently approached a total of 15 eligible patients to explain the study objectives. Out of these, 4 patients declined to participate due to fatigue or time constraints. The final sample consisted of 11 patients. Data saturation was achieved by the 10th interview, at which point no new information or themes emerged, and the 11th interview was conducted to confirm this saturation.

Inclusion criteria:

1) Pathologically diagnosed with Uterine Cervical Neoplasms, with a FIGO stage of I-III; 2) Completed primary anti-tumor therapy (surgery, chemotherapy, or radiotherapy) for ≥3 months, and currently in the Extended Survival Meriod; 3) Conscious and possessing normal verbal communication skills; 4) Provided informed consent and volunteered to participate in this study.

Exclusion criteria:

1) Experienced tumor recurrence or metastasis; 2) Diagnosed with concurrent severe psychiatric illnesses or cognitive impairments; 3) Currently in the acute phase of a major family life event (e.g., bereavement or divorce).

A total of 11 participants (M1-M11) were ultimately included. The demographic and clinical characteristics of the participants are presented in **Table 1**.

Table 1. General characteristics of participants.

Participant ID	Age (years)	Educational Level	Premorbid Occupation	Insurance Type	FIGO staging	Treatment Modality	Post-Treatment Duration (months)	Comorbidities	Marital Status	Cohabitation Status	Primary Caregiver
M1	35	Associate degree	Self-employed	Resident BMI	IB	Surgery	26	HTN, DM	Married	Living with spouse	Husband
M2	45	Secondary school	Self-employed	Employee BMI	IIA	Surgery	22	DM	Married	Living with spouse	Husband
M3	57	Secondary school	Salesperson	Resident BMI	IIA	Surgery	3	HTN, DM	Married	Living with spouse	Husband
M4	38	Secondary school	Farmer	Out-of-pocket	IA	Surgery	5	DM	Married	Living with spouse	Husband
M5	40	Secondary school	Farmer	Out-of-pocket	IA	Surgery	10	HTN	Married	Living with spouse	Husband
M6	49	Associate degree	Self-employed	Resident BMI	IIB	Surgery + Chemotherapy + Radiotherapy	12	DM	Married	Living with spouse	Husband
M7	58	Bachelor's degree	Farmer	Resident health insurance	IIB	Surgery + Chemotherapy + Radiotherapy	15	DM	Married	Living with spouse	Husband
M8	50	Primary school	Farmer	Resident BMI	IA	Surgery	9	HTN	Married	Living with spouse	Husband

Continued

M9	60	Primary school	Self-employed	Out-of-pocket	IIA	Surgery	11	HTN	Married	Living with spouse	Husband
M10	62	Primary school	Employee	Employee BMI	IB	Surgery	13	DM	Married	Living with spouse	Husband
M11	56	Secondary school	Employee	Employee BMI	IIA	Surgery	14	DM	Married	Living with spouse	Husband

Note: BMI = Basic Medical Insurance; HTN = Hypertension; DM = Diabetes Mellitus.

2.2. Research Methods

2.2.1. Developing the Interview Outline

Based on the Transitions Theory framework and a thorough literature review, a semi-structured interview outline was designed. The outline encompassed dimensions such as family role transitions, body image and self-cognition, and exploring barriers to reintegration. Specific questions included: 1) After completing your treatment and returning home, what changes have occurred in your daily life? 2) What difficulties have you encountered when caring for family members or managing household chores? 3) Have physical changes (such as scars or edema) affected your intimate relationship with your partner? 4) In what areas do you most desire assistance or support?

2.2.2. Data Collection Methods

Data collection was conducted by researchers who had undergone systematic training in qualitative research methodologies. Interviews were held in a private, quiet environment, with each session lasting between 30 and 45 minutes. The researchers adopted an active listening approach, utilized open-ended questions, and synchronously documented the participants' non-verbal behaviors (e.g., sighing, crying, or silence). All participants signed an informed consent form, and the study strictly adhered to the principles of confidentiality.

2.2.3. Data Analysis Methods

Within 24 hours of completing each interview, the audio recordings were transcribed verbatim into text. Data analysis was performed utilizing Colaizzi's seven-step phenomenological method [5]: 1) Familiarizing oneself with the data; 2) Identifying significant statements; 3) Formulating meanings; 4) Clustering themes; 5) Developing exhaustive descriptions; 6) Producing the fundamental structure; and 7) Seeking verification from participants.

2.2.4. Ethical Statement

This study obtained informed consent from all participating patients. Throughout the entire research process, the research team strictly complied with relevant ethical guidelines and maintained the utmost confidentiality regarding patients' personal data and privacy.

3. Results

Through rigorous analysis, a total of 3 core themes and 11 sub-themes emerged from the data.

3.1. Transition Conditions: From "Passive Endurance" to "Active Reconstruction"

Transition conditions refer to the personal and environmental factors that either facilitate or hinder the patients' transition back to a normal life.

3.1.1. Accepting an Altered Body Image

In the early stages, participants generally experienced a "sense of bodily incompleteness." However, over time, some patients engaged in cognitive reappraisal, viewing their surgical scars as the price of survival and ultimately accepting them.

M3: "At first, when I saw the scar and darkened skin on my abdomen, I didn't even dare look in the mirror. Now I've gradually come to terms with it; this scar is my badge of honor for beating cancer, as long as I am still alive."

3.1.2. Reconstructing Female Identity

Confronting the "sense of loss" brought on by a hysterectomy, patients attempted to shift their perceived value as women from their "reproductive organs" to their "emotional roles."

M8: "After having my uterus removed, I used to feel incomplete. Now I realize that motherhood isn't about having a uterus, but about whether I can still love my child and my family."

3.1.3. Activating Family Emotional Support

Non-verbal support from spouses and children (such as massages and simple companionship) served as a crucial condition for patients attempting to rebuild their sense of security.

M1: "After I got sick, although my husband is a man of few words, he washes my feet and massages my legs (to prevent edema) every day. This silent support makes me feel that our home is still our home."

3.1.4. Acquiring Sexual Rehabilitation Knowledge

A correct understanding of the appropriate timing and methods for resuming intimacy effectively alleviated the patients' anxiety.

M5: "I just wanted to know when we could resume intimacy and whether it would hurt. Later, the doctor gave me a booklet, which put my mind at ease so I wouldn't worry unnecessarily."

3.2. Transition Barriers: Dual Physical and Psychological Constraints

These represent the core barriers hindering patients from reintegrating into family life, encompassing multiple physiological, psychological, and social dimensions.

3.2.1. The "Freezing" of Marital Intimacy

Participants generally reported that despite the completion of their treatment, intimate interactions with their spouses had stagnated. Physiological pain (vaginal dryness and stenosis) and psychological distress (fear of recurrence, fear of rejection) became intertwined, ultimately leading to sexual avoidance.

M1: "The doctor said we could resume intimacy, but he didn't dare touch me, and I was also terrified of the pain. We ended up sleeping in separate rooms for half a year. It felt like we were drifting further and further apart, like strangers living under the same roof."

3.2.2. Frustration in the Traditional "Good Wife and Loving Mother" Role

Heavily influenced by traditional cultural norms, patients experienced profound guilt when physical decline prevented them from managing household responsibilities.

M6: "In the past, I took care of everything inside and out for our family. Now, even mopping the floor gives me a severe backache. Looking at the messy house and knowing I still need my husband to come home and clean it up makes me feel incredibly useless, like a complete burden."

3.2.3. Social Stigma Associated with Lymphedema

The physical alterations caused by lower-limb edema led patients to experience social withdrawal during family gatherings or outings.

M9: "Look at my leg, it's swollen like an elephant's. I can't fit into any of my old skirts anymore. I'm afraid of people staring at me when I go out, and I don't even dare to go community dancing anymore; I just hide at home."

3.2.4. Fear of Cancer Recurrence and Abandonment

Uncertainty regarding the future frequently evolved into excessive anxiety over the stability of their marriages.

M4: "Sometimes I wake up in the middle of the night and think, what if it comes back? Will he still take care of me like this? Will he despise being tied to a sick person and eventually divorce me?"

3.3. Response Patterns: Divergence in Coping Strategies

When confronted with these barriers, patients adopted varying coping mechanisms, which directly impacted their transition outcomes.

3.3.1. Dyadic Coping and Communication Attempts

Some patients attempted to communicate openly with their partners to confront rehabilitation challenges together, reflecting a positive form of dyadic coping.

M2: "I gathered the courage to have a talk with him and shared my fears. He also opened up about his concerns. Even though I haven't completely recovered yet, the emotional knot between us has loosened somewhat."

3.3.2. Solitary Endurance and Protective Buffering

A majority of patients opted for "protective buffering," attempting to maintain a facade of family harmony by concealing their pain; however, this strategy inadvertently exacerbated their sense of isolation.

M10: "It's dry and painful down there. I'm too embarrassed to mention it to the doctor, l*et al.*one my husband. I just endure it every time, treating it as fulfilling my marital obligation, because I don't want to disappoint him."

3.3.3. Seeking Peer Support and Empathy

When family support proved insufficient, patients frequently turned to peer support groups to find a sense of belonging.

M7: "I met several sisters in the support group. Only they truly understand the embarrassment of the 'hot flashes' and 'urinary leakage.' We cheer each other on, which makes me feel like I am not fighting this battle alone."

4. Discussion

4.1. Role Conflict and Internalized Stigma within the Cultural Context

This study found that the involuntary relinquishment of the traditional "good wife and loving mother" role is a prominent psychological barrier for patients attempting to reintegrate into family life. Within the Chinese cultural context, women often closely tie their self-worth to household management. Research indicates that stigma is highly prevalent among patients with Uterine Cervical Neoplasms and is negatively correlated with self-efficacy [6]. A hysterectomy represents not only the loss of a physical organ but is often symbolized as the termination of feminine traits, ultimately leading to internalized stigma. The study by Zheng Yingying *et al.* [7] further noted that the symptom experiences during the rehabilitation period directly impact patients' psychological well-being. Therefore, nursing professionals should assist patients in establishing realistic rehabilitation expectations, introduce "role supplementation" strategies, help families negotiate new divisions of labor, and validate the patients' crucial value in maintaining family emotional bonds.

4.2. Breaking the "Collusive Silence" in Intimate Relationships

The widespread phenomena of "bedroom separation" and the mutual avoidance of sexual topics between spouses constitute a negative form of "protective buffering" within the dyadic coping model [8]. This phenomenon aligns with recent systemic reviews and clinical guidelines which highlight that sexual dysfunction remains a critically unaddressed gap in gynecological cancer survivorship, one that directly disrupts dyadic intimacy [9] [10]. Furthermore, recent quantitative evidence based on the Actor-Partner Interdependence Model (APIM) demonstrates the profound bidirectional influence of dyadic communication on coping strategies in cervical cancer couples [11]. Although this silence originates from a desire for mutual protection, it effectively severs emotional connection. Qualitative research by Shi Yan *et al.* [3] confirmed that experiences related to sexual intimacy represent the most profoundly hidden distress for patients with Uterine

Cervical Neoplasms post-surgery, directly impacting marital quality. Furthermore, a review by Huang Rong *et al.* [12] emphasized that while sexual dysfunction is a common complication for Uterine Cervical Neoplasms Survivors [13], it is frequently overlooked in clinical practice. Clinical nurses should actively incorporate the PLISSIT (Permission, Limited Information, Specific Suggestions, Intensive Therapy) counseling model into discharge planning to destigmatize discussions regarding sexual health and encourage couples to jointly participate in sexual rehabilitation education [14]-[16].

4.3. Building an Integrated "Hospital-Community-Family" Support System

During the interviews, the patients' heavy reliance on peer support highlighted a significant gap in professional transitional care. Currently, domestic follow-up care predominantly focuses on recurrence monitoring, lacking systematic guidance regarding lymphedema management, menopausal symptoms, and psychological adaptation [17]. Niu Yanzhi *et al.* [18] pointed out that family resilience serves as a vital resource for cancer patients navigating crises. Drawing upon a recent systematic review and meta-analysis of family resilience in adult oncology [19], we argue that survivorship care plans must transition from individual-centric approaches to inclusive frameworks that foster collective family adaptation. It is recommended to draw upon international experiences to develop personalized "survivorship care plans," utilize digital platforms to disseminate rehabilitation skills [20], and organize family workshops. These interventions can enhance the caregiving capabilities and empathy levels of spouses, thereby providing patients with more robust safeguards at the social support level [21]-[23]. This approach aligns seamlessly with the perspective of "providing high-quality medical and rehabilitation resources through multiple channels," as proposed by Fu Lian *et al.* [24] in their research on colorectal cancer.

5. Conclusion

Uterine Cervical Neoplasms Survivors face unique barriers related to body image, intimate relationships, and role identity during the Extended Survival Meriod. Healthcare professionals must remain highly attentive to these deep-seated psychological needs. By providing comprehensive informational support, facilitating effective dyadic communication, and constructing robust social support networks, medical staff can empower patients to successfully navigate the identity transition from "cancer patient" to "healthy woman."

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

[1] Zheng, R.S., Chen, R. and Han, B.F. (2024) Cancer Incidence and Mortality in China,

2022. *Chinese Journal of Oncology*, **46**, 221-231. (In Chinese)

[2] Jiang, Y.L., Mu, X.L. and Chen, Y.R. (2022) Psychological Resilience and Its Correlation with Quality of Life in Postoperative Patients with Cervical Cancer. *Journal of International Psychiatry*, **49**, 160-163. (In Chinese)

[3] Shi, Y., Cai, J. and Wu, Z.M. (2019) A Qualitative Study on the Dyadic Relationship Experience of Patients after Radical Hysterectomy for Cervical Cancer. *Chinese Journal of Nursing*, **54**, 1825-1830. (In Chinese)

[4] Im, E.O. (2011) Transitions Theory: A Trajectory of Theoretical Development in Nursing. *Nursing Outlook*, **59**, 278-285.e2. https://doi.org/10.1016/j.outlook.2011.03.008

[5] Liu, M. (2019) The Application of Colaizzi's Seven-Step Method in Phenomenological Data Analysis. *Journal of Nursing Science*, **34**, 90-92. (In Chinese)

[6] Li, R., Li, G.Q. and Yan, R. (2016) The Current Status of Stigma in Patients with Cervical Cancer and Its Related Influencing Factors. *Modern Clinical Nursing*, **15**, 1-5. (In Chinese)

[7] Zheng, Y.Y., Lyu, H.Y. and Chen, Z.F. (2020) A Qualitative Study on the Symptom Experience and Psychological Feelings of Patients During Recovery after Radical Hysterectomy for Cervical Cancer. *Chinese Journal of Nursing*, **55**, 569-573. (In Chinese)

[8] Chen, X.F. (2019) Analysis of Influencing Factors on Postoperative Sexual Quality of Life in Patients with Cervical Cancer. *China Practical Medical*, **14**, 64-65. (In Chinese)

[9] Pizetta, L.M., Reis, A.d.C., Méxas, M.P., Guimarães, V.d.A. and de Paula, C.L. (2022) Management Strategies for Sexuality Complaints after Gynecologic Cancer: A Systematic Review. *Revista Brasileira de Ginecologia e Obstetrícia/RBGO Gynecology and Obstetrics*, **44**, 962-971. https://doi.org/10.1055/s-0042-1756312

[10] Peleg Nesher, S., Luria, M., Sartorius, G., Tripodi, F., Lew-Starowicz, M., Both, S., *et al.* (2025) Clinical Practice Guidelines: Sexual Dysfunction in Gynecological Cancer Patients. *Sexual Medicine*, **13**, qfaf066. https://doi.org/10.1093/sexmed/qfaf0066

[11] Zhi, S., Gu, W., Miao, R., Zhang, L., Jing, X., Ramachandran, H.J., *et al.* (2024) Associations between Dyadic Communication and Dyadic Coping of Patients with Cervical Cancer and Their Spouses: A Study Utilizing the Actor-Partner Interdependence Model. *Supportive Care in Cancer*, **32**, Article No. 90. https://doi.org/10.1007/s00520-023-08304-2

[12] Huang, R., Huang, H. and Zeng, L.H. (2021) Research Progress on Sexual Dysfunction in Cervical Cancer Survivors. *Chinese General Practice Nursing*, **19**, 3766-3770. (In Chinese)

[13] Zhen, H.N., Tian, Y. and Shen, J. (2019) Analysis of Quality of Life and Sexual Function after Radiotherapy for Cervical Cancer. *Chinese Journal of Radiation Oncology*, **28**, 597-600. (In Chinese)

[14] Hill, E.K., Sandbo, S., Abramsohn, E., Makelarski, J., Wroblewski, K., Wenrich, E.R., *et al.* (2011) Assessing Gynecologic and Breast Cancer Survivors' Sexual Health Care Needs. *Cancer*, **117**, 2643-2651. https://doi.org/10.1002/cncr.25832

[15] Cheng, Y., Hu, C.M. and Gao, M. (2022) Analysis of Quality of Life and Transitional Care Needs in Postoperative Patients with Cervical Cancer. *Journal of Chengdu Medical College*, **17**, 208-213. (In Chinese)

[16] Li, Q.Q., Yao, L. and Wang, T.S. (2026) A Visual Analysis of Research Progress on Sexual Health in Cervical Cancer Patients. *Maternal and Child Health Care of China*, **41**, 384-388. (In Chinese)

[17] Hou, R. and Xu, A.L. (2017) The Effect of Psychological, Functional, and Social Support Nursing on Quality of Life in Postoperative Cervical Cancer Patients. *Chinese Journal of Reproductive Health*, **28**, 256-258. (In Chinese)

[18] Niu, Y.Z., Li, Y. and Huang, X.L. (2022) Research Progress on Family Resilience in Cancer Survivors. *Medicine & Philosophy*, **43**, 55-58. (In Chinese)

[19] Ashley, A., Marsh, K., Ling, J., *et al*. (2025) Family Resilience in Adult Oncology: A Systematic Review and Meta-Analysis. *Oncology Nursing Forum*, **52**, 228-240.

[20] Xu, Y.F., Zhu, J.L. and Qu, H.H. (2024) The Effect of Extended Care Based on WeChat Platform on Postoperative Quality of Life in Patients with Cervical Cancer. *Shanxi Medical Journal*, **53**, 138-141. (In Chinese)

[21] Gong, P.F., Xia, B.R. and Lou, G. (2016) Mediating Effect of Hope Level on Quality of Life and Perceived Social Support in Postoperative Cervical Cancer Patients. *Chinese Journal of Public Health*, **32**, 965-967. (In Chinese)

[22] Ding, X.T. and Zhang, R.H. (2023) The Influence of Family Function on Disability Acceptance in Patients after Radical Mastectomy: The Chain Mediating Role of Family Resilience and Self-Concealment. *Modern Medical Journal*, **51**, 1617-1623. (In Chinese)

[23] Zhang, T.C., Chen, H.Y. and Tan, J.F. (2026) Study on the Relationship between Quality of Life and Social Support in Cervical Cancer Patients and Strategies for Improvement. *Soft Science of Health*, **40**, 12-17. (In Chinese)

[24] Fu, L., Ding, C.Y. and Xue, J.Y. (2025) A Qualitative Study on the Experience of Returning to Normal Life among Colorectal Cancer Patients in the Extended Survival Phase. *Journal of Nursing* (*China*), **32**, 67-72. (In Chinese)