

# UNIT 7

## Sexual Health

Dr. Anne Katz, RN, PhD

## Quick Overview text box.

- Up to 80% of cancer survivors will experience some alterations in sexual functioning as part of the cancer trajectory.
- It is important for the nurse to recognize that sexual challenges are present at all stages of cancer and to offer assessment and assistance where needed.
- It is most common for cancer survivors and their partners to seek help when treatment is complete and life goes back to 'normal'.
- Sexuality is very much a cancer survivorship issue.

## Introduction

All people are sexual beings from birth to death. Awareness of one's sexual self begins in early childhood and is maintained despite illness, relationship status, or actual sexual activity. Cancer and its treatments pose a significant threat to a person's sexual self-image as well as to how they are able to express their sexuality.

Up to 80% of cancer survivors will experience some alterations in sexual functioning as part of the cancer trajectory (Meyerowitz, Desmond, Rowland, Wyatt, & Ganz, 1999); whether they choose to seek help for this is variable. It is important for the nurse to recognize that sexual challenges are present at all stages of the cancer experience and to offer assessment and assistance where needed (Rolland, 2005). Alterations to sexuality and sexual functioning can occur anywhere along the cancer trajectory, from diagnosis to end of life. It is most common for cancer survivors and partners to seek help when treatment is complete and life goes back to 'normal', thus sexuality is an important cancer survivorship issue.

## Link to relevant CANO/ACIO Standards

Attending the sexual health needs of the cancer survivor and partner is relevant to many of the CANO/ACIO Standards of Care including: individualized and holistic care; family centered care; and supportive and therapeutic relationships. For the specialized oncology nurse refer to the Standards and Competencies for the Specialized Nurse Domain #1 Comprehensive Health Assessment; Domain # 3 Management of Cancer Symptoms and Treatment of Side Effects; and Domain #4 Teaching and Coaching.

## Literature Review

### Changes to Sexual Functioning and Sexuality

Alterations to sexual functioning and sexuality most commonly manifest in the following ways: body image issues, changes to sexual anatomy, alterations in physiological functioning, and emotional responses to these changes. The following discussion will briefly highlight some of the most important issues; more in-depth explanations are found in the resources presented at the end of this section.

### *Body Image Issues*

Treatment for cancer usually involves some combination of surgery, radiation therapy, chemotherapy, and endocrine manipulation (Katz, 2007). Any and all of these may impact on body image. The presence of scars as well as weight gain or loss may profoundly alter the way a person sees themselves as a sexual being. The area around a scar may feel numb or be hyper-sensitive to touch. Skin changes as a result of radiation therapy may have similar results. No matter how much reassurance the person receives from their partner, their sexual self image may be altered and they may be reluctant to appear naked in front of their partner or may avoid sexual touching (Schover et al., 1995).

Any and all kinds of surgery may affect body image even though it may seem minor. For example, women who have lumpectomy rather than mastectomy may experience alterations to their body image because of the scar that remains on the breast or because the shape of the breast is different.

### *Changes to Sexual Anatomy*

The surgical removal of body parts or organs that directly affect sexual functioning include mastectomy, radical prostatectomy, and hysterectomy. Other surgeries close to the pelvic area (such as the rectum) may also interrupt blood or nerve supply to the area and thus affect sexual functioning. After radical prostatectomy, many men find that their penis undergoes shrinkage as a result of lack of blood flow from nocturnal erections (Munding, Wessells, & Dalkin, 2001).

### *Alterations in Physiological Function*

After surgery, scar tissue in the area of the surgery may alter various phases of the sexual response cycle. For example, some women find that after hysterectomy their orgasms feel different, usually as a result of the loss of contractions of the uterus during the contraction phase of orgasm (Gruhmann, Robertson, Hacker, & Sommer, 2001). Women who have been treated for breast cancer may need to take hormone manipulating medications such as aromatase inhibitors; these are known to cause vaginal dryness that causes pain with intercourse (dyspareunia) and often leads to lack of interest in sex (lack of libido) because the woman is fearful about experiencing pain (Bentrem & Jordan, 2002). Similarly, men with advanced prostate cancer may need to take androgen deprivation therapy which leads to significant loss of libido and this has been shown to impact negatively on the intimate relationship (Navon & Morag, 2003).

### *Emotional Responses*

Many couples do not anticipate what it means to deal with something that previously was natural and spontaneous. Some couples find it difficult to talk about what has happened to their sex life and may drift apart. Others are able to deal effectively with this change and seek help or find other ways to maintain intimacy in the relationship. There is no right or wrong way to deal with sexual changes after cancer but it is important that cancer survivors and their partners are aware that sexual changes are likely to occur and how to access resources to help them cope. (Refer to Unit 6: Relationships and Unit 8: Psychosocial Health and Wellbeing for more information about emotional responses.)

### **Fertility**

Many of the treatments for cancer can affect fertility. This is of special importance when a child, adolescent, or young adult is treated for cancer. In males, the testicles (and hence sperm production) are more susceptible to damage before puberty so a man who was treated for cancer in childhood may be infertile (Lambert & Fisch, 2007). When cancer is diagnosed after puberty, it is advised that all young men have sperm frozen and stored for future use. This is a difficult decision for the young man and his parents as the decision has to be made when the cancer survivor and family are in shock about the diagnosis (Schover, Brey, Lichtin, Lipschultz & Jeha, 2002).

There are fewer options for fertility preservation in young women. After puberty the ovary is susceptible to damage from both chemotherapy and radiation. Shielding the ovaries or moving them out of the field of radiation does help to prevent damage. The only proven method of preserving fertility in women is to harvest eggs which are then fertilized by the partner's sperm and the resultant embryos are frozen for implantation at a future date. This option is not available to adolescents who are not partnered. Freezing unfertilized eggs or ovarian tissue remains experimental (Davis, 2006).

Understanding the impacts of cancer and cancer treatment on fertility is important for the nurse in the setting of cancer survivorship. In this course of the cancer experience cancer survivors and their partners may be living with the reality of never conceiving a child together. They may be experiencing continued disappointment, grief or distress. It is important to be considering this within the nursing assessment and exploring it appropriately. Some individuals or couples may need focused counseling in follow up and referrals to supportive care practitioners may be indicated.

It is important for couples to know that assuming that the person who has had cancer is infertile may result in an unexpected pregnancy. Some cancer survivors may not use condoms for contraceptive purposes and this puts them at risk for acquiring sexually transmitted infections.

## Facilitating a Systematic Assessment

As a holistic care provider who sees cancer survivors and their partners over time, the nurse is ideally situated to assess for sexual problems related to the cancer and/or its treatment and to make suggestions to help with identified problems. This is certainly within the scope of nursing practice however many nurses state that they do not feel comfortable discussing this with patients (Magnan, Reynolds, & Galvin, 2005). Others state that they do not know enough about the topic and so do not assess their patients.

The resources provided in this unit will provide the factual content to enable the nurse to provide the answers to most questions that cancer survivors will ask. Increasing personal comfort with talking about the topic may be challenging, but may improve with experience.

It is vital that an assessment of sexual functioning and any difficulties encountered be done at regular intervals during treatment and follow-up. There are a number of ways to assess sexuality and sexual functioning in the cancer survivor. The two models described below are simple to use and easy to remember.

The **PLISSIT Model** (Annon, 1974) is a 4-level model that suggests deepening levels of enquiry and assessment.

The first level is that of **permission**. Using a non-threatening opening question or suggestion, the nurse indicates to the cancer survivor that he/she is willing to listen to any sexual concerns. A statement such as “Many men who have been treated for prostate cancer experience some degree of difficulty achieving or maintaining an erection. I can provide you with information that you may find useful if you have any questions about this or anything else.”

The second level is that of **limited information**. All nurses should be able to give this kind of information when working with cancer survivors in their area of practice. An example of this level of assessment/intervention is: “The vaginal dryness you describe since starting on tamoxifen is quite common. There are a number of things that can help, starting with a vaginal moisturizer such as Replens®. You may also want to use a lubricant such as Astroglide® for sexual activity”.

The third level of this model is **specific suggestion**; this requires a more in-depth knowledge of sexuality and cancer but most expert nurses should be able to provide this level of assessment/intervention. A statement such as “Because you did not have a nerve-sparing procedure when they removed your prostate, the oral medications used to treat erectile dysfunction will not work. You will have to consider more mechanical or invasive methods such as the vacuum pump or penile self-injection”.

The final level, **intensive therapy**, is best left to a sexuality counselor/therapist or specialist. It is important for the nurse to know about the local resources available to cancer survivors with concerns about sexuality. For example there may be resources such as sexuality counseling, sexuality clinics, and pelvic physiotherapy to name a few.

The second model, the **BETTER model** (Mick, Hughes and Cohen, 2003) was developed for use in oncology settings. It is similar to the PLISSIT Model in that the first level of intervention involves bringing up the topic (B). The second letter (E) involves explaining that sexuality is part of quality of life, and cancer survivors should be aware that they can talk about this with the nurse. The nurse should then tell (T) the cancer survivor that appropriate resources will be found to address their concerns and that while the timing (T) may not be appropriate now, they can ask for information at any time. Cancer survivors should be educated (E) about the sexual side effects of their treatment and finally, a record (R) should be made in the chart to report that this topic has been discussed.

A more detailed discussion about assessment of sexuality can be found in the text *Breaking the Silence on Cancer and Sexuality: A Handbook for Health Care Providers* by Anne Katz RN PhD (Oncology Nursing Society, 2007).

## Priority Content for Patient Teaching

Many cancer survivors who experience sexual difficulties do not know where to go for help. The nurse may be the first and only person to ask about this important part of life and must be prepared to help the cancer survivor find the help that they need and want. When a problem is identified, nurses should have on hand the names and contact information for sexuality counselors or therapists, marital and family therapists, or psychosocial clinicians who may be able to help.

## Additional Resources

### WEBSITES

<http://www.cancerbackup.org.uk/Resourcessupport/Relationshipscommunication/Sexuality>

Website from the UK. Information for patients and their partners.

[http://www.cancer.org/docroot/MIT/MIT\\_7\\_1x\\_SexualityforWomenandTheirPartners.asp](http://www.cancer.org/docroot/MIT/MIT_7_1x_SexualityforWomenandTheirPartners.asp)

American Cancer Society website. For women.

[http://www.cancer.org/docroot/MIT/MIT\\_7\\_1x\\_SexualityforMenandTheirPartners.asp](http://www.cancer.org/docroot/MIT/MIT_7_1x_SexualityforMenandTheirPartners.asp)

American Cancer Society. For men.

<http://www.mayoclinic.com/health/cancer-treatment/SA00071> Mayo Clinic.

## BOOKS

Alterowitz, Ralph & Alterowitz, Barbara. *Intimacy with Impotence: The Couple's Guide to Better Sex after Prostate Disease*. Cambridge, MA: Da Capo Lifelong Books, 2004.

Kahane, Deborah H. *No Less a Woman: Femininity, Sexuality and Breast Cancer*. 2nd rev. ed. Alamedam, CA: Hunter House, 1995.

Katz, A. (2009). *Woman Cancer Sex*. Hygeia Media: Pittsburgh, PA.

Katz, A. (2009). *Sex when you're Sick: Reclaiming Sexual Health after Illness or Injury*. Greenwood: New York, NY.

Katz, A (2009). *Man Cancer Sex*. Hygeia Media: Pittsburgh, PA.

Laken, Keith. *Making Love Again: Hope for Couples Facing Loss of Sexual Intimacy*. Sandwich, MA: Ant Hill Press, 2002.

Perlman, Gerald & Drescher, Jack. *A Gay Man's Guide to Prostate Cancer*. Binghamton, MA: The Haworth Press, 2005.

### **The following books and articles will be helpful for nurses who want to learn more about the topic of cancer and sexuality.**

Katz, A. (2009). Interventions for Sexuality after Pelvic Radiation Therapy and Gynecological Cancer. *The Cancer Journal: The Journal of Principles & Practice of Oncology*, 15 (1), 45 – 47.

Katz, A. (2009). It's Getting Better All The Time: Gays and Lesbians in Cancer Care. *Oncology Nursing Forum*, 36 (2), 203 – 207.

Katz, A. (2009). Fertility preservation in young cancer patients. *American Journal of Nursing*, 109 (4), 44 – 47.

Katz, A. (2009) Sexuality. In *Canadian Fundamentals of Nursing* 4th edition. Elsevier. (in press).

Katz, A. (2008). Gay, Lesbian, Bisexual and Transgender Clients in Lynnette Stamler and Lucia Yiu (Eds) *Community Health Nursing: A Canadian Perspective* 2nd Ed. Pearson Education Canada: Toronto, Ont.

Katz, A. (2007) *Breaking the Silence on Cancer and Sexuality: A Handbook for Health Care Professionals*. Oncology Nursing Society: Pittsburgh, PA.

## Case Study

J.P. is 54-year-old. Three weeks ago she was diagnosed with breast cancer after a routine screening mammogram. She was scheduled for a lumpectomy and will have radiation after that. You see J.P. in follow up when she returns to see the surgeon who performed the lumpectomy. She is alone and very upset. J.P. tells you that her husband has barely made eye contact with her since the surgery and appears to be withdrawing. He has not touched her at all since the surgery and they used to have a very active and satisfying sex life. J.P. is feeling very much alone and is worried that, “there is something very wrong” with her husband’s reactions following her breast surgery. She is not sure how she will manage to get through the radiation therapy without him.

Apply either the PLISSIT or BETTER Model to suggest a statement or question to begin your interaction with Jill.

What further questions should you ask?

What advice can you give J.P. at this time?

Who is the best resource to refer J.P. to and when is an appropriate time to make the referral?

## Answers

J.P.’s husband’s response is not unusual and may be his way of coping with the new circumstances of their life. There is no right or wrong way to cope. He may not actually be withdrawing but rather trying to find a new way of coping with the situation. He would likely benefit from some counseling on his own as well as some couples’ counseling.

It would be helpful to ask J.P. what her expectations of her husband are and how he is meeting or failing these expectations. Assessing her other means of support would also be important at this time. It would also be helpful to explore what kind of touching she is referring to. She may mean sexual touching of her breasts or she may mean that he avoids any kind of physical contact with her, including hugging or holding her hand when she needs it.

A referral to a social worker as soon as possible is a good place to start. This professional will be able to identify other resources that may be needed to help this couple to deal with their coping and adaptation. A referral to a support group may also be useful.

## References

- Annon, J. (1974). *The Behavioral Treatment of Sexual Problems*. Honolulu: Enabling Systems.
- Bentrem, D. & Jordan, C. (2002). Role of antiestrogens and aromatase inhibitors in breast cancer treatment. *Current Opinion in Obstetrics and Gynecology*, 14, 5-12.
- Davis, M. (2006). Fertility considerations for female adolescent and young adult patients following cancer therapy: A guide for counseling patients and their families. *Clinical Journal of Oncology Nursing*, 10 (2), 213 – 219.
- Gruhmann, M., Robertson, R., Hacker, N., & Sommer, G. (2001). Sexual functioning in patients following radical hysterectomy for stage IB cancer of the cervix. *International Journal of Gynecological Cancer*, 11, 372-380.
- Lambert, S. & Fisch, H. (2007). Infertility and testis cancer. *Urologic Clinics of North America*, 34, 269 – 277.
- Magnan, M. A., Reynolds, K. E., & Galvin, E. A. (2005). Barriers to addressing patient sexuality in nursing practice. *Medsurg.Nurs.*, 14, 282-289.
- Meyerowitz, B. E., Desmond, K. A., Rowland, J. H., Wyatt, G. E., & Ganz, P. A. (1999). Sexuality following breast cancer. *Journal of Sex and Marital Therapy*, 25, 237-250.
- Mick, J., Hughes, M., & Cohen, M. (2003). Sexuality and cancer: How Oncology Nurses Can Address It BETTER. *Oncology Nursing Forum*, 30, 152-153.
- Munding, M., Wessells, H., & Dalkin, B. (2001). Pilot study of changes in stretched penile lengths 3 months after radical retropubic prostatectomy. *Urology*, 58, 567-569.
- Navon, L. & Morag, A. (2003). Advanced prostate cancer patients' relationships with their spouses following hormonal therapy. *Eur.J.Oncol Nurs.*, 7, 73-80.
- Rolland, J. (2005). Cancer and the family: An integrative model. *Cancer*, 104, 2584-2595.
- Schover, L. R., Yetman, R., Tuason, L., Meisler, E., Esselstyn, C., Hermann, R. et al. (1995). Partial mastectomy and breast reconstruction: A comparison of their effects on psychosocial adjustment, body image, and sexuality. *Cancer* 75, 54-64.
- Schover, L., Brey, K., Lichtin, A., Lipschultz, L. & Jeha, S. (2002). Knowledge and experience regarding cancer, infertility, and sperm banking in younger male survivors. *Journal of Clinical Oncology*, 20 (7), 1880 – 1889.