What Should I Say? Talking With Patients About Sexuality Issues

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Sexual problems are common in most patients during and following cancer treatment and are especially frequent in survivors of breast cancer (50%), gynecologic cancer (50%), and prostate cancer (70%). The problems can be severe and generally persist over time (Schover, 2004).

Sexual and reproductive function is affected by all aspects of cancer, including cancer’s biologic processes of growth and metastasis, the effects of undergoing cancer treatment, and the psychological issues that occur as a result of having cancer and receiving treatment for it. These aspects can result in changes in body appearance, infertility and sterility, and the inability to have intercourse. The changes may be made worse by additional alterations in body image, fears of abandonment, loss of self-esteem, changes in sexual identity, and concerns about self (Krebs, 2005).

Human sexuality includes three separate but intertwined aspects: body image, reproductive ability, and sexuality or sexual functioning. Body image, or the way individuals see themselves or think others see them, may be altered by changes in body appearance resulting from weight loss or gain, alopecia, mucositis, fatigue, or a variety of other changes that may not be visible to others. Changes in self-esteem may occur as a result of body image alterations, resulting in decreased desire and decreased sexual activity. Reproductive function, or the ability to bear or father children, may become impossible as a result of therapy-related infertility, and sexual functioning may be altered by changes in self-perception, decreased desire, general side effects of treatment (including cancer therapies and methods to manage side effects of therapy), or numerous other reasons. Some individuals are at higher risk for sexual side effects than others based on age, gender, type of cancer, type of cancer treatment, or concomitant medical or psychological illness (Krebs, 2001, 2005). See Figure 1 for a list of factors that contribute to sexual difficulties.

Pathophysiology

In men and women, three hormones regulate gonadal function. Any alteration in hormone production as a result of disease, cancer treatment, psychological factors, or nutritional status can result in sexual or reproductive dysfunctions. The hormones affected are included in the following list (Deneris, Huether, & Robinson, 2004).

**Men and Women**
- Gonadotropin-releasing hormone from the hypothalamus
- Luteinizing hormone and follicle-stimulating hormone from the anterior pituitary

**Women**
- Estrogen and progesterone from the ovaries

**Men**
- Testosterone produced by the interstitial Leydig cells

Influence of Cancer Treatment on Sexuality

Chemotherapy

Sexual and reproductive dysfunctions related to the administration of chemotherapy, hormonal agents, or biologics (see Figure 2) may be temporary or permanent. The effect of the newer targeted agents on sexual functioning remains, for the most part, unclear. In general, sexual side effects are related to one or more of the following individual drug characteristics (Krebs, 2005).
Type of drug (particularly alkylating agents)  
Dose of each drug administered  
Length of treatment  
Age  
Prior fertility status.

**Treatment of Sexual Dysfunction**

Treatment of sexual dysfunction depends on whether the alterations caused by cancer or treatment are permanent or temporary as well as whether current treatment exists, is medically indicated, and is available and acceptable to the patient. Possible treatments include management of (Krebs, 2005)  
Menopausal symptoms (hot flash management with medications or herbs)  
Erectile dysfunction  
Infertility (sperm banking).

**Nursing Assessment and Intervention Strategies**

**Sexual Assessment**

Several methods of sexual assessment have been identified (Andersen & Lamb, 2005).

**Chemotherapeutic Agents**

- Amenorrhea  
- Premature menopause  
- Erectile dysfunction  
- Azoospermia or oligospermia  
- Decreased libido  
- Potential for drug to be excreted in human milk  
- Potential teratogenic effects on fetus if pregnant

**Stem Cell and Marrow Transplant**

- Decreased sexual desire and satisfaction  
- Vaginal atrophy  
- Decreased lubrication  
- Painful intercourse  
- Premature ejaculation resulting from prolonged abstinence  
- Impotence or erectile dysfunction  
- Body image changes  
- Chronic fatigue  
- Chronic gastrointestinal disturbances

**Hormonal Agents**

- Masculinization in women  
- Increased or decreased libido  
- Impotence  
- Gynecomastia  
- Hot flashes  
- Irregular menses  
- Acne

**Surgery**

Depending on the surgical site, changes in sexuality may be temporary or permanent. Removal of reproductive organs results in permanent sterility and may alter sexual functioning. Surgery to other areas should not affect fertility but may alter sexual function because of changes in body image and psychosocial concerns (Krebs, 2005).

**Radiation Therapy**

Effects of radiation therapy on sexuality and fertility also may be temporary or permanent. Permanent effects most commonly are related to (Krebs, 2005)  
- Total dose  
- Location

**Biologics**

- Flulike symptoms  
- Fatigue  
- Mucous membrane dryness  
- Body image changes  
- Decreased libido  
- Erectile dysfunction  
- Gynecomastia  
- Impotence  
- Amenorrhea  
- Pelvic pain  
- Spontaneous abortions  
- Fetal malformations

**Note.** Based on information from Krebs, Mosby, 2006; Wilkes & Barton-Burke, 2005.
Assessment
ALARM Model (Andersen & Lamb, 1995)
Activity (sexual)
Libido or desire
Arousal or orgasm
Resolution, release, or relaxation
Medical information (cancer and past and concomitant health status)

Schover Method (Schover, 1998)
Evaluate past and present
• Sexual practices
• Sexual function
• Sexual relationships
Evaluate current
• Status of cancer
• Status of cancer treatment
• Concomitant medical condition
• Psychological condition. Identify sexual knowledge, desires, and goals.

PLISSIT Model (Annon, 1976)
Permission (to have sexual feelings and relationships)
Limited Information (about effects of treatment or cancer on sexuality)
Specific Suggestions (to manage sexual side effects)
Intensive Therapy
(The first three usually can be accomplished by a healthcare provider; the last may require referral to a sex therapist or counselor.)

Figure 3. Methods of Assessment and Intervention

1995; Mick, Hughes, & Cohen, 2004). Annon (1976) also developed the PLISSIT (permission, limited information, specific suggestions, intensive therapy) model, which can be used to focus interventions.

Once sexual functioning has been assessed, intervening to maintain optimal functioning and promote adaptation to sexual and reproductive side effects of cancer and cancer treatment is essential (see Figure 3).

Patient and Family Education
Patient and family education is essential. It should include information about
• The impact of disease, therapy, and side effect management on sexual and reproductive functioning
• Reproductive counseling, including the use of adequate birth control, methods to maintain fertility, and reproductive options following therapy
• Sexual alternatives, resources, and side effect management, including prostheses, lubrication, dilators, hot flash management, and education
• Available counseling and support services.

Understanding and Facilitating Patient Goals
Nurses need to help patients and family members, as appropriate, to
• Find acceptance of themselves.
• Feel and appear attractive.
• Positively manage intimate relationships.
• Maintain or enhance their ability to give and receive affection.
• Maintain usual confidence in sexual situations.

Using Guidelines to Discuss Sexuality and Support Sexual Rehabilitation
Many strategies are important to facilitate the discussion of sexuality issues. Among them are to
• Use sensitivity and timing when talking with patients.
• Start with factual information and move from less sensitive to more sensitive areas.
• Take cues from patients to talk about issues important to them.
• Include patients’ significant others, as appropriate.
• Communicate interest, be nonjudgmental, and give permission to be sexually active and discuss sexual issues.

• Be prepared to offer basic information, reassurance, support, and hope.
• Follow up on discussions and refer patients to other healthcare professionals or resources when appropriate.

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References