Receiving a cancer diagnosis and experiencing the effects of antineoplastic therapies can have a devastating effect on a person’s emotional, physical, and psychological well-being and a significant negative effect on sexual desire and function. Oncology nurses are the ideal healthcare professionals to assess the sexual health status of their patients and to intervene to sensitively address sexuality issues. Having this discussion can be uncomfortable for both nurses and patients, but using communication tools can help nurses gain confidence in their abilities to address sexuality concerns in an effective and comfortable manner and to provide patients with useful information and insights.

M.R. is a 35-year-old married woman diagnosed with acute myeloid leukemia (AML). She has been married for two years and reports having a good marriage. Her husband has been closely involved with her treatment and appears to be very supportive. She has completed her second cycle of chemotherapy as an inpatient on the oncology unit and is being discharged later in the day. The oncology nurse enters the room and sees that M.R. is alone in her hospital room, sitting on her bed, crying. She immediately asks what is wrong. M.R. states that she is afraid of going home. When the nurse asks her what she fears about going home, M.R. responds, “I’m just so tired, I don’t know how I’ll be able to have sexual care if I never have sex again.” She says that she is afraid of being thought of as a “bad wife” who doesn’t try to please her husband after all he’s done for her. This is the point at which the oncology nurse has the opportunity to address M.R.’s sexual concerns in a knowledgeable and sensitive manner.

Sexuality and Cancer

Receiving a diagnosis of cancer and experiencing the effects of therapy can have a devastating effect on a person’s emotional, physical, and psychological well-being and self-image and can lead to significant quality-of-life changes in sexual desire, function, and pleasure (Horder, 2008). Any of the therapies used in cancer treatment, including chemotherapy, hormonal agents, biologics, surgery, and radiation, can cause sexual dysfunction during or after treatment, either of a temporary or prolonged nature. Survivors of cancers of the breast, the female reproductive system, and the prostate are especially likely to experience sexual dysfunction (Krebs, 2006).

Studies have confirmed that patients prefer their healthcare providers to take the lead in inquiring about their sexual health (Julien, Thom, & Kline, 2010); however, many nurses wait for the patient to open this discussion. Among the reasons for this inaction may be that nurses feel inadequately prepared for this discussion or embarrassed to speak about issues of sexuality and intimacy, do not wish to offend the patient, presume that issues of survival should take precedence over issues of sexuality, or feel that it is not part of their role. Nurses also cite a lack of relevant education and time and patients’ poor physical conditions as barriers to sexual health assessment and intervention (Julien et al., 2010). However, as part of holistic oncology nursing practice, the Oncology Nursing Society (ONS) and the American Nurses Association (ANA) recommend assessment and data collection about patients’ past and present sexual relationships, effects of disease and treatment on body image and sexual function, and the psychological response of patients and partners to disease and treatment (ONS & ANA, 2004).

Sexuality Intervention and Assessment Tools

Nurses are experienced and comfortable in discussing issues relating to diagnosis, treatment, and rehabilitation with patients, but often are uncomfortable and unsure of themselves in initiating conversations about sexuality with patients or responding to their concerns about
sexual issues (Mick, 2007). To help support nurses in addressing intimate issues with patients, two models for sexual assessment and intervention are described: PLISSIT and BETTER.

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**PLISSIT Model**

PLISSIT is a four-step model that was first conceptualized by Annon (1976). It provides a systematic approach to learning about a patient’s sexual concerns and discussing supportive interventions based on four sequential intervention levels requiring increasing knowledge and expertise (Annon, 1976; Katz, 2005) (see Figure 1).

**BETTER Model**

The BETTER model was developed specifically for oncology nurses to help guide them in assessing and discussing sexuality issues with their patients as part of a holistic quality-of-life framework. BETTER employs a step-wise sequence to help facilitate communication between patient and nurse about the sensitive issues of intimacy, sexuality, and sexual dysfunction (Mick, 2007; Mick, Hughes, & Cohen, 2003, 2004). In comparison with PLISSIT, additional components of the BETTER model include the timing of the sexuality discussion and documenting that it took place (see Figure 2). A listing of organizations that provide information about sexuality for this population can be found in Table 1.

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**The Sexuality Discussion**

After hearing M.R.’s concerns about how she can manage to be a sexual person in the face of fatigue and lack of sexual desire, the oncology nurse understands that this is the appropriate moment to intervene and decide to do so using the steps in the PLISSIT model. First, the nurse gives M.R. permission (P) to address the topic by asking her if she would like to discuss her sexual concerns at this time. When she says “yes,” the nurse provides privacy by closing the door and then sits beside M.R. in the bedside chair. The nurse listens carefully as M.R. expresses her feelings of sexual inadequacy and then responds with limited information (LI) appropriate to M.R.’s situation. The nurse explains that fatigue and lack of sexual desire are frequent side effects of the chemotherapy she received to treat AML and that many patients undergoing cancer therapies have the same experience. However, M.R. exclaims “But what am I supposed to do?” This statement prompts the nurse to offer M.R. specific suggestions (SS) for sharing intimacy with her husband. The nurse explains that sexual intercourse is not the only way to show love and affection and that they both might enjoy hugging, kissing, touching, and mutual massage. The nurse also describes strategies for energy conservation, including choosing a time of day for intimate contact when her energy level is highest, such as in the morning. M.R., although still skeptical that the suggestions will work, appears calmer and less fearful about going home. The nurse suggests that M.R. and her husband try the specific strategies and reassures her that a follow-up discussion will take place after discharge. Two days later, when the oncology nurse makes the discharge phone call to M.R. at home, the issue of sexuality is brought up and M.R. states that she and her husband have been using some of the suggestions and they seem to be adequate for now. They have not attempted sexual intercourse because she is still fatigued, but she feels close to her husband and realizes that she isn’t a “bad wife.” M.R. thanks the nurse for her concern and useful suggestions. In this case, M.R. and her husband did not need to advance to the intensive therapy (IT) step of PLISSIT because the specific side effects of therapies.

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**P = Permission**

By being open and honest and initiating a discussion about sex, the healthcare professional gives the patient permission to express concerns, needs, and feelings related to sexual function. Patients also are reassured that their feelings are shared by others in the same situation.

**LI = Limited Information**

Patients are given limited information specific to their situation and sexual concerns, such as adverse physiologic changes from effects of treatment or disease on sexual function, change in body image, and lack of libido.

**SS = Specific Suggestions**

Specific suggestions are provided to help patients manage or compensate for sexual dysfunction. Suggestions may include discussion of comfortable sexual positions and alternate methods of expressing closeness and intimacy, or interventions to provide vaginal lubrication or diminish fatigue.

**IT = Intensive Therapy**

Intensive therapy is the step where the sexuality intervention has reached the level at which the services of a trained specialist are indicated. The first three levels of sexual counseling on the part of the healthcare professional have not resulted in resolution of the patient’s problems and an outside referral is needed.
suggestions have been sufficient at this time to help M.R. and her husband mutually express their intimate feelings for each other despite her cancer diagnosis and treatment side effects.

**Conclusion**

Having a discussion regarding sexuality can be uncomfortable for both nurses and patients. Using communication tools such as PLISSIT or BETTER can help nurses gain confidence in their abilities to address sexuality concerns in an effective and comfortable manner and to provide patients with useful information and insights. Nurses are the healthcare providers who spend the most time with patients and, as part of holistic nursing practice, they are expected to possess the knowledge and level of confidence to sensitively address issues of sexuality with their patients.

**References**


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Supportive Care provides readers with information on symptom management and palliative care issues. Length should be no more than 1,000–1,500 words, exclusive of tables, figures, insets, and references. If interested, contact Associate Editor Marcelle Kaplan, RN, MS, AOCN®, CBCN®, at marcelle.kaplan@gmail.com.