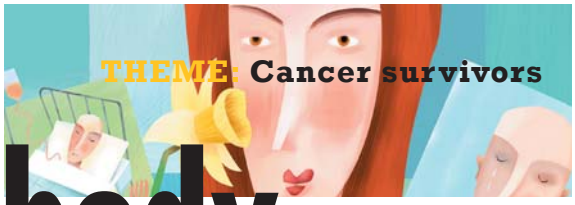

Sexuality and body image after cancer

Kendra Sundquist, Lesley Yee

BACKGROUND Cancer and its treatments can profoundly affect a person's sexuality including their body image, sexual functioning, relationships, identity and self esteem. One of the more common long lasting effects of cancer treatment is sexual dysfunction, yet for a number of reasons, health practitioners may not adequately address these topics.

OBJECTIVE This article describes the range of factors contributing to psychosexual problems for people with cancer and provides a useful framework for addressing problems and taking a sexual history.

DISCUSSION More than half of all people diagnosed and treated for cancer in Australia now survive their disease. Many of these survivors suffer from significant physical and emotional changes during and after their cancer treatments that affect their sexuality and sexual functioning. Such patients need an opportunity to discuss these changes with their health practitioners, but all too often are not given the opportunity to do so.

Kendra Sundquist, EdD, MHlth, Sc(Ed), RN, MCN(NSW), is Program Specialist, Professional Education and Training, The Cancer Council, New South Wales.

Lesley Yee, MBBS (Hons), MMed (Psychotherapy), FACSHP, FACPsychMed, is a general practitioner and sexual counsellor in private practice, Sydney, New South Wales.

There is evidence that health practitioners are not comfortable discussing the issues of sexuality and sexual functioning in cancer survivor patients, are not fully knowledgeable regarding loss or change in sexual function secondary to cancer treatment, or do not feel they have the skills to appropriately raise these issues with their patients.[1]

Psychosexual impact of cancer

The psychosexual impact of cancer and its treatments is influenced not only by the physical changes that affect body image and sexual function, but by other factors such as whether the person is in a current sexual relationship, the quality of the sexual relationship, and to a certain extent the person's age.

Cancers that potentially have the greatest impact on sexuality body image and sexual functioning are:

- breast
- prostate
- colorectal
- gynaecological
- testicular, and
- head and neck cancers.

Treatments for cancer including surgery, chemotherapy, radiation and hormonal therapy, can all negatively impact on sexual functioning and fertility (Table 1).

It has been estimated that approximately half the women who survive breast cancer report severe sexual problems.[2] After a mastectomy women are particularly vulnerable, with younger women being twice as likely to experience sexual problems than older women.[3] Women who are given hormonal treatment for breast cancer have decreased circulating oestrogens which can cause loss of sexual desire, vaginal dryness and painful sexual intercourse.

Even with nerve sparing surgery for prostate cancer, impaired sexual function may still be a significant problem, particularly over time. There is also a risk of urinary incontinence, though this improves over time for the majority of patients. It has been estimated that between 62–88% of men and women experience sexual dysfunction after surgery for colorectal cancer when pelvic autonomic nerves are damaged.[4] Psychosexual dysfunction is higher in patients with a stoma, compared to those with intact sphincters.[5,6]

Table 1. Factors contributing to psychosexual problems

Effects of treatments

- fatigue, nausea, hair loss
- loss of libido, erectile dysfunction
- loss of fertility, induced menopause
- reduced/lack of vaginal lubrication
- reduced/lack of orgasmic response
- loss of/changes to body parts, sexual organs
- incontinence
- lymphoedema
- weight gain or loss

Effects of disease process

- weight loss, muscle loss
- anaemia, pale skin
- anxiety, depression, loss of libido
- pain, fatigue
- incontinence
- neurological impairment
- ascites
- loss of sensation

Table 2. Barriers to taking a sexual history

- lack of time
- fear of intruding or offending patient
- belief that cancer survivors may be too ill, or are not interested in sex
- belief that disfigured bodies are not sexually attractive
- fear of boundary transgressions and medicolegal implications
- lack of adequate training and/or skills in this area
- cultural issues – gay patient, single patient, different cultural beliefs about illness and disease
- age and gender of patient – young patient, old patient
- presence of a third party (partner, parent)
- fear of opening a 'Pandora's box' – previous sexual assault, difficult relationship

Table 3. Key points when taking a sexual history

- create privacy and confidentiality
- make no assumptions
- be aware of past sexual abuse
- be aware of cultural issues
- be nonjudgmental and respectful
- use gender neutral terms
- avoid jargon or technical terms
- recognise own biases

History taking

For many cancer survivors, anxiety over having a life threatening disease, adjusting to the changes that have occurred in their sexual functioning, body image, and in their intimate relationships can be difficult. Negative emotions such as anger, resentment, grief, or unresolved conflict need to be discussed.

Cancer patients, particularly those who are older, are often reluctant to broach the topic of sex and because of this doctors may incorrectly assume they have no concerns.[7,8] Often a consultation with their practitioner is the only legitimate place where a patient is able to bring up their sexual problems. There are numerous barriers that may make taking a sexual history in cancer patients difficult in the general practice setting (Table 2).

Taking a sexual history in cancer patients is best incorporated in the normal medical framework. A full medical history must be taken, including psychiatric history and any drug, medications or substances that the patient is using. It should be recognised that many drugs and medications will influence sexual performance. The key points in sexual history taking are outlined in Table 3.

The practitioner will need to use open ended questions which seek the patient's permission to discuss sexual issues. Time must be allowed to provide appropriate information and to explore the patient's responses. Some examples of open ended questions to ask cancer patients are shown in Table 4.

PLISSIT model

A model of counselling for sexual difficulties that fits well in a general practice setting is the PLISSIT model (Table 5).[9] Developed in the 1970s, it pro-

Table 4. Open ended questions to ask cancer patients

Many cancer patients I see experience some difficulties in their sex lives. How has this been for you?
What difference has cancer made to how you feel about yourself or your body?
Has your sexual functioning changed due to your cancer or its treatment?
What difference has cancer made to the quality of your relationship?
How has your partner reacted to your cancer?

Table 5. PLISSIT model

Permission
Practitioner provides the opportunity and initiates discussion about sexuality
Limited information
Factual information provided with appropriate resources
Specific suggestions
Identifies the problem and may require further knowledge
Intensive therapy
Problems are severe, prolonged, pre-existing or more in depth
Patient may need to be referred to a specialist

vides a model for the practitioner to provide help with sexual problems, progressing from a brief intervention to more intensive therapy where necessary.

This framework allows the practitioner to define their role to their own level of skill, knowledge and experience. Each stage requires increasing professional competence and allows referral when the practitioner feels they have insufficient knowledge or are uncomfortable with the topic.

It is important that the patient feels they are supported in a holistic approach which focusses on their quality of life, their intimate relationships, and their social situations. The patient may express a range of beliefs, attitudes and feelings about sex, and about having cancer.

Conclusion

Practitioners often feel most comfortable when talking from a position of knowing the subject matter. On sexual issues, the practitioner must listen empathically to the individual patient. Even if they do not have the information required at that moment, much can be done if they allow their patients an opportunity to air their concerns. Simple suggestions such as the use of vaginal lubricants, local oestrogen creams or products to facilitate erectile function may be all that is required for some patients. More complex situations will often require time and further discussion. General practitioners are ideally placed to develop strong ongoing relationships with their cancer patients where they can work with them to arrive at creative solutions for their sexual functioning and body image problems.

SUMMARY OF IMPORTANT POINTS

- Cancer and its treatments can have a significant psychosexual impact on body image, sexual functioning and intimate relationships.
- Patients are reluctant to broach the topic of sex with their health practitioner.
- A full medical history must be taken including psychiatric history and medications being taken.
- Patients must feel supported in a holistic approach that focusses on their quality of life, intimate relationships and social situation.
- The PLISSIT model provides a useful counselling framework to assist patients with their sexual problems.

Conflict of interest: none declared.

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Resource

Talking about sexuality body image and cancer: A teaching resource for health professionals. The Cancer Council NSW, 2002. (Accredited by the RACGP as a Category one CPD activity).

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Dr Kendra Sundquist
Professional Education and Training
The Cancer Council NSW
153 Dowling St
Woolloomooloo, NSW 2011
Email: kendras@nswcc.org.au