

# Communicating about Sexual Problems

## Parler des difficultés sexuelles

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**Abstract** Sexual side effects of cancer treatment are common and, unfortunately, often not discussed with patients and their partner. This may be due to personal factors of the health care provider, fear of offending the patient or lack of knowledge, time constraints, and perception of the importance to the patient based on age and severity of the cancer. Despite the barriers to communication about a sensitive topic, oncology care providers are well situated to initiate the conversation. This article will identify key issues related to communication about sexuality by oncology care providers with individuals with the most common kinds of cancer. Models for assessing sexuality in these patients are presented to facilitate communication about this important aspect of quality of life that is impacted by cancer treatment.

**Keywords** Cancer · Communication · Sexuality

**Résumé** Les effets secondaires sexuels des traitements anticancéreux sont courants et, malheureusement, souvent non abordés avec les patients et leur partenaire. Cela peut être dû à des facteurs personnels des professionnels de santé, à la peur d'offenser le patient, à un manque de connaissances, à des contraintes de temps ou à la perception de l'importance de la sexualité pour le patient en fonction de son âge et de la gravité de sa maladie. Malgré les obstacles à la communication sur un sujet sensible, les professionnels de santé en oncologie sont bien placés pour engager la conversation. Cet article identifie les questions clés liées à la communication sur la sexualité par les professionnels de santé en oncologie avec les personnes atteintes des types de cancer les plus fréquents. Des modèles d'évaluation de la sexualité de ces patients sont présentés afin de faciliter la communication sur cet aspect important de la qualité de vie qui est affecté par les traitements du cancer.

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## Introduction

Sexual side effects of cancer treatment are common and, unfortunately, often not discussed with patients and their partner. This may be due to personal factors of the health care provider, fear of offending the patient or lack of knowledge, time constraints, and perception of the importance to the patient based on age and severity of the cancer [1]. However, patients want information about any changes they may experience [2] and this is especially important when the cancer affects organs related to sexual functioning [3].

A number of studies have reported the challenges of both patients and providers in providing and receiving information about sexual changes during and after treatment for a variety of cancers. Communication in breast cancer is the most studied, along with prostate and gynecologic cancer, but treatments for all cancers potentially impact sexual functioning. There is a discrepancy in reports of discussion of sexual concerns with health care providers reporting a greater incidence of discussion (88%) than patients (50%) [4]. Discussions are more likely to be reported by men (60%) than women (28%).

This article focuses on the need for communication about sexual changes during and after treatment for a variety of cancers.

## Breast cancer

In a study of recorded visits of women with breast cancer and oncology care providers, a third of the women reported sexual problems but discussion of this occurred in just 45% of these patients [5]. Forty percent of patient visits included some communication about sexual health and most (70%) communication was initiated by the health care provider. Patient factors play a role in this area. Patients' beliefs about their ability to discuss sexual problems and their

perception of how the health care provider will respond impact on whether they raise the topic or not [6].

A positive patient–provider relationship is essential for the discussion about sexual changes after treatment; patients prefer open communication while providers prefer communication focused on interventions such as referral to specialists [7]. Topics most often discussed are body image, cessation of sexual activity, safety of sexual activity, and vaginal dryness [5]. One study suggests that patients may not always recall a discussion about sexuality and this may be influenced by how important this is for the individual patient [8].

## Prostate cancer

Despite the well-known sexual side effects of treatment for prostate cancer [9] and the established physical and emotional needs of prostate cancer survivors [10], there is variability in how information about sexual challenges is provided [11]. Patients may be reluctant to talk about their sexual concerns because they are more focused on survival initially, feel that the psychological aspects of sexual functioning are seen as secondary to the more mechanical aspects, and experience communication from providers that is not focused on them as individuals or part of a couple [12]. The needs of gay and bisexual men are neglected and they comprise a hidden population [13], and the predominately heteronormative advice provided to men with prostate cancer does not meet their unique needs [14].

## Gynecologic cancer

The sexual side effects of treatment for gynecologic cancer are significant and are shown to impact negatively on sexual activity. One study reported that women experienced a decrease in sexual enjoyment from 64.7% one year before treatment to 27.4% one year later [15]. Most women (78.7%) agree that sexual function is important for overall health and that health care providers should ask about this regularly [16] and a minority of women (12.0%) felt embarrassed talking about this.

Embarrassment may play a role in the reluctance of women to talk about their sexual concerns.

A recent systematic review [17] found that embarrassment on the part of the woman, as well as the perceived discomfort of the health care provider, is a barrier to communication. Another barrier was the belief that sexual functioning is not just a physical entity but rather multidimensional and health care providers are not equipped to address complex issues. Systemic barriers to accessing help with sexual problems were also identified; these include limited time, the perception

by patients that their health care provider had a heavy workload, inadequate resources, and lack of privacy.

Facilitators of communication about sexual side effects of cancer include knowledgeable practitioners, assessment of risks and need for information or intervention, symptom management, positive provider–patient relationships, accessible psychosexual care as well as psychosocial support [18], and appropriate timing of assessment as well as multiple forms of patient education materials [17].

## Assessing sexual function

Opening a discussion about sexual functioning falls within the capability of all oncology providers who address sensitive topics such as end-of-life care on a regular basis, while comprehensive education about sexuality is not part of most medical [19] or nursing programs [20]. While lack of specific knowledge of sexuality is cited as a barrier to talking about the sexual side effects of treatment, it is not an expectation that oncology care providers be experts in this area. However, they must be able to ask general questions and refer patients for expert care just as they do for other side effects.

There are a number of models that are available to assist the oncology care provider in this regard. These include the PLISSIT model [21], the 5As model [22], and the CARD model [23].

The PLISSIT model [21] is divided into four sections that build on each other and involve a deeper level of information with each step. The first step, permission, asks the patient whether they have any concerns about sexuality or sexual functioning. An example of this is a statement such as “Many women experience sexual changes after treatment for breast cancer. What concerns do you have?” The second level, limited information, should address common concerns and all oncology care providers should be able to provide information at this level. Most often, the information for the patient addresses normalization and validation of what the patient is experiencing. The third level, specific suggestion, includes providing guidance on the use of prescription medications, information about lubricants for vulvo-vaginal atrophy, and other targeted interventions. Finally, intensive therapy refers to providing the patient with access to other resources such as sex therapists, psychologists, endocrinologists, and gynecologists for expert care.

The 5As model [22] involves the following steps:

- Ask about any sexual concerns;
- Assess by asking specific questions;
- Advise the patient that help will be found for their concerns and/or make suggestions about interventions that can be provided;

1. **Are you presently sexually active?**
2. **Are you satisfied with the quality of your sex life?**
3. **Are there any sexual problems or worries that you would like to discuss with me today?**
4. **Sometimes people who suffer from cancer have sexual issues. What would you like to discuss with me today?**

**Fig. 1** Four opening questions

- Assist the patient in finding resources to address their concerns;
- and finally Arrange for follow-up to find out what help they found useful and how their concerns are resolving.

The CARD model [23] echoes the other models described by providing an opening statement: “Cancer treatment can affect our sexual health which is important for many people and for couple’s quality of life.” The second level, Ask, involves asking broad or specific questions about any sexual concerns that the patient may be experiencing based on their treatment history and the known side effects of their treatments. Suggesting Resources and/or Referrals echoes the other models described and allows the patient to agree to further interventions such as referral to a therapist or medical specialist. The final level is that of Documentation in the patient chart that the issue of sexual concerns has been raised.

The health care provider does not need to be an expert in sexuality to initiate the conversation with the patient; using the models described above, problems can be identified and interventions can be offered. Most health care providers should know enough to validate and normalize the concerns of the patient at a minimum. It is also important to know where to refer patients whose concerns exceed the knowledge of the health care provider.

For those who wish to address sexual concerns on a deeper level, there are a number of steps involved in the taking of a sexual history [24]. Figure 1 presents four questions that can be used to begin this process.

More specific questions can be asked based on the response to this initial inquiry, including specific questions and information related to sexual side effects of cancer treatment. These questions should be based on the care provider’s knowledge of the sexual side effects of treatment, for

example, asking about vulvo-vaginal dryness for women on aromatase inhibitors.

## Conclusion

This article has identified key issues related to communication about sexuality by oncology care providers with individuals with the most common kinds of cancer. Models for assessing sexuality in these patients were presented to facilitate communication about this important aspect of quality of life that is impacted by cancer treatment. Despite the barriers to communication about a sensitive topic, oncology care providers are well situated to initiate the conversation.

**Links of interest:** The author declares that she has no links of interest

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