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Sexuality and Cancer: The Final Frontier for Nurses

Mary K. Hughes, MS, RN, CNS, CT
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Although I had been a member of the Oncology Nursing Society (ONS) since the 1980s, it was not until 1991 that I first attended Congress. That year, Dorothy Smith, from the University of Texas M.D. Anderson Cancer Center, delivered the Mara lectureship, and I was thrilled to be present because I had worked with Dot. Alas, I am no Dot Smith, but I do hope I inspire many of you to address sexuality issues with your patients.

We talk about everything with our patients—bowel and bladder habits, nausea and vomiting—but we do not address sexuality issues. It is the last frontier for us, and I will give you tools to use to help make you more comfortable addressing these issues. Our patients think they are the only ones with sexual concerns because we talk about everything else with them. When they are in the waiting room, they chat with each other about everything but sexuality issues. So they feel very lonely and isolated with these concerns.

It is very hard for us to think about sexuality and cancer at the same time because they do not seem to go together. When you think about sexuality, you usually use positive or neutral words, but cancer usually is associated with negative words. We are very focused on treating cancer and forget about sexuality and its importance to patients.

Defining Sexuality

According to Winze and Carey (1991), sexuality is genetically endowed, phenotypically embodied, and hormonally nurtured. Smith (1994) described sexuality as being matured by experience and something that cannot be bought, sold, or destroyed, despite what is done to a person. It is not age related because humans are sexual beings in utero (Whipple & Komisaurak, 1999). The World Health Organization (2002) further described sexuality as including pleasure, sexual activity, eroticism, and sexual orientation. It is a broad term that encompasses love of one's self as well as love of another,

body image, intimacy, relating to another, pleasure, and reproduction (Southard & Keller, 2009). Southard and Keller went on to describe sexual quality of life as having a mind/body connection, feeling attractive and potent, having choices, and being able to enjoy sexual activities. Being able to trust (not only your partner, but your body to perform and respond to sexual stimulation) is a very important part of sexual quality of life. Sexual quality of life involves stimulation of all of the senses—smell, touch, taste, hearing, as well as seeing—and includes a positive and respectful approach to each other (World Health Organization).

Leiblum, Baume, and Croog (1994) asserted that patients of all ages, sexual orientations, marital statuses, and life circumstances should have the opportunity to ask about and discuss sexual matters with healthcare professionals. How do we promote and encourage such discussion?

Cancer's Effects on Sexuality

The problems one experiences when diagnosed with and treated for cancer that affect sexuality include erectile dysfunction, decreased libido, and vaginal dryness. Urinary incontinence can make it embarrassing to be involved with sexual activity for fear of an accident. Likewise, bowel dysfunction can interfere with sexual functioning because if constipation is a problem, women will experience discomfort with sexual activity, and if diarrhea is a problem, there is discomfort as well as fear of incontinence. Fatigue is the longest-lasting side effect from cancer treatment and interferes with all aspects of sexuality in the same way anemia does. It takes energy to engage sexually. Some people are concerned about birth-control issues and are not able to use their prior forms of contraception (e.g., women with breast cancer cannot use oral contraceptive pills). Pain interferes with all aspects of sexual functioning because efforts to control pain distract from other activities. Muscle loss from inactivity or steroid use makes