Sexuality and Intimacy

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Why is this important?

- Increasing number of people surviving cancer
- Increasing awareness of quality of life
- Cancer and cancer treatments can all impact on sexual function
- 40-100% of cancer patients experience some form of sexual dysfunction
- With intervention, up to 70% of patients can have improved functioning (Vachani, 2006)
- Frequently overlooked by healthcare professionals (Stilos, Doyle & Daines, 2008)

Sexuality

- Beliefs, attitudes and feelings about sexuality tied to our cultural, moral, spiritual/ religious beliefs
- Feelings we have about ourselves as sexual beings
- Different meanings and importance for each of us
- Own ways of expressing our sexuality

Gynaecological Cancer: Sexuality and Intimacy

"…..sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors"(WHO, 2005)

Sex one domain of intimacy
Emotional connection & sharing
Shared activities & goals
Intellectual sharing
Spiritual connection

Surgery
- Scars /body image
- Infertility
- Surgical menopause
- Shortened vagina

Chemo/Hormonal:
- Ovarian failure

Pelvic radiation
- Pelvic vascular fibrosis
- Nerve damage
- Vaginal fibrosis

Psychological Effects
Cancer diagnosis-crisis phase
All stages may impact on sexuality and sexual functioning
Couples experience-Relationship changes

Cancer: Sexuality and Intimacy

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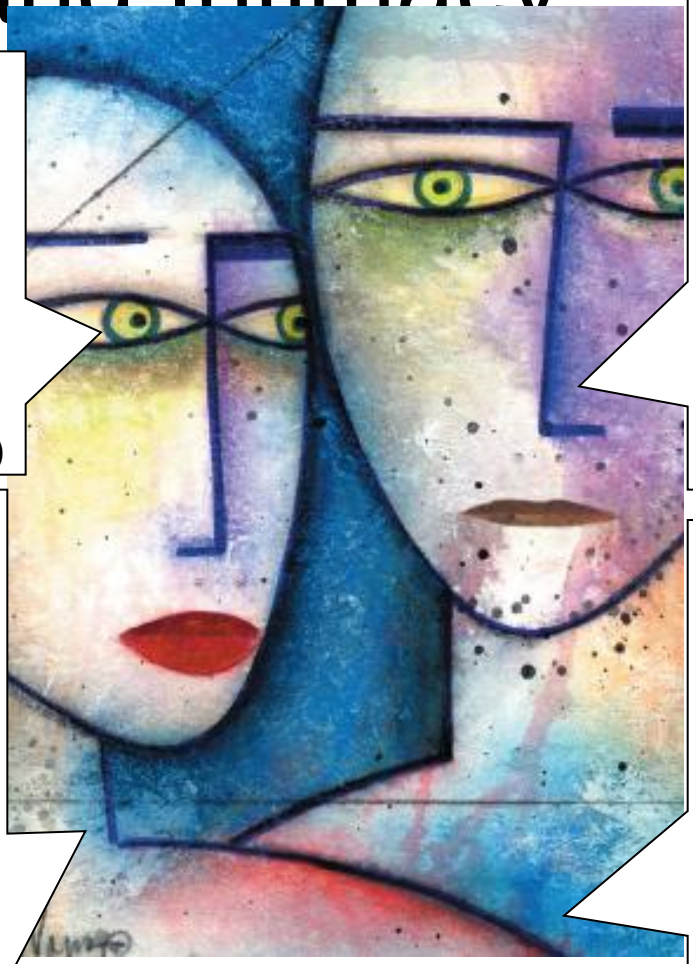

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Sexual dysfunctions (SDs)

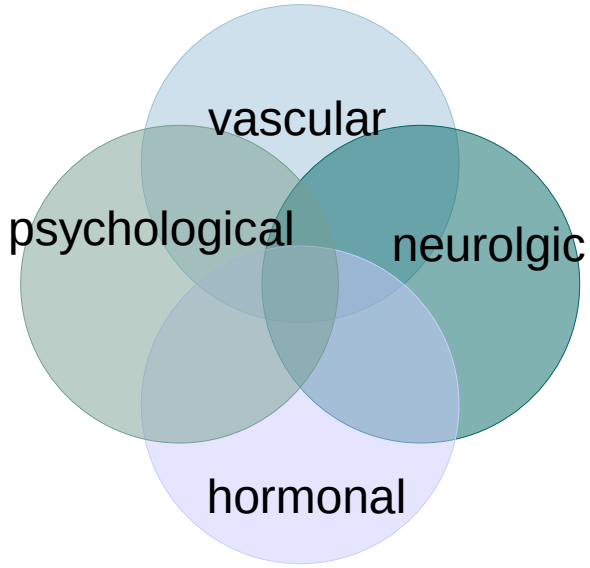
- Characterised by a disturbance in
  - sexual desire
  - psychological and physiological changes that characterise the sexual response (The Diagnostic and Statistical Manual of Mental Disorders (4th edition DSMIV-TR 2000)
- Only a problem if the person is identifies it is a problem
- No ‘normal’

Sexual Function

- 80% men and 65% women had sexual intercourse during the past year.
- Most common dysfunctions
  - Premature ejaculation (14%) — Men
  - Erectile difficulties (10%) — Women
  - Lack of sexual interest (21%) — Women
  - Inability to reach orgasm (16%) — Women
  - Lubrication difficulties (16%) .
- Overall, 28% men and 39% women reported at least one sexual dysfunction (Nicolosi et al., 2004)

Sexual Function and Cancer

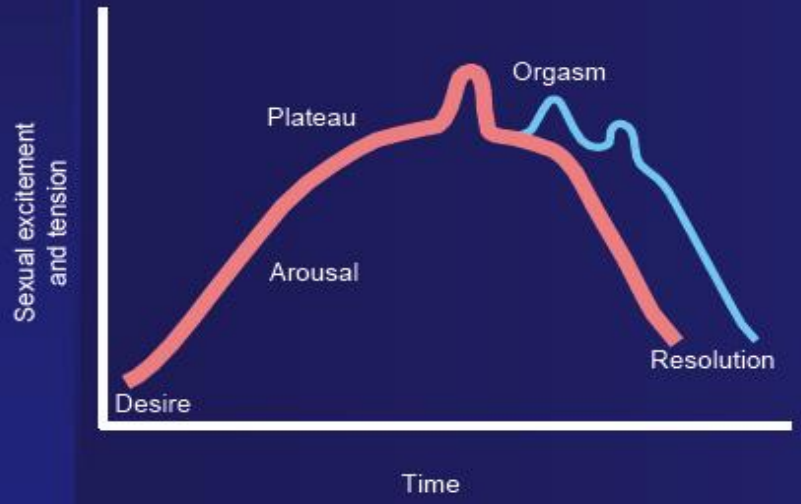
- Sexual response



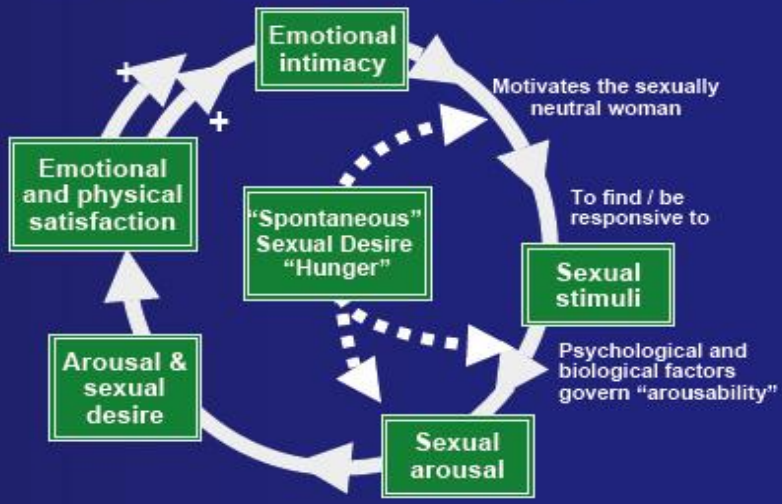
- Complex
- Multifactorial
- Most common sexual problems
  - Loss of desire
  - Dyspareunia
  - Vaginal dryness

Sexual Response Cycle Evolution

- Traditional, Linear, Function-Based Kaplan Model



- Contemporary, Non-Linear, Subjectivity-Based Basson Model



Adapted with Permission from: Basson R. Obstet Gynecol 2001;98:350-3.

Premature Menopause

- FSD is most common around middle age
- Higher frequency sexual dysfunctions and more distress after surgical menopause
- Hypoactive sexual desire disorder (HSDD) increases with age- assoc distress inversely correlated with age
- Natural menopause-48% women low desire
- HSDD- surgical menopause 32% Vs 19% premature menopause (Graziottin, 2010)

Hormones

- Oestrogens are modulators of sexual response
- Vasoactive intestinal polypeptide (VIP)
- “translates” desire and central arousal into vaginal congestion and lubrication.
- Loss of oestrogen
  - Decreased sexual desire
  - vaginal dryness
  - Dyspareunia
  - loss of self-confidence/self-esteem
  - increases anxiety and concerns
- Testosterone initiating role on desire and central arousal
- Dopaminergic appetitive-seeking pathway
- Modulator role of the peripheral response,
- Permissive factor for nitric oxide (NO),
- Main mediator of clitoral and cavernosal bodies congestion

Loss of androgens

- Central and peripheral arousal
- Decreased sexual desire
- Causes/worsens orgasmic difficulties
- (Graziottin, 2010)

Gonadotoxic Chemotherapy	
Alkylating agents:	Busulfan Cyclophosphamide Ifosfamide Melphalan
Platinum	Cisplatinum
Nitrosureas	Carmustine Lomustine
Others	Procarbazine

(Bashore, 2007)

Jean Hailes
For Women's Health

Libido

What is libido?
Your libido is your sexual interest and desire, otherwise known as your 'sex drive'. Libido varies from woman to woman and can be influenced by a range of different factors. Loss or reduction of libido may be experienced by women of any age and may result in reduced desire to have sex and/or sexual experiences that are no longer satisfying or pleasurable. All women will experience low libido at some time in their lives – this may be prolonged or short term (e.g. after the birth of a baby, during a stressful life period or when a relationship is rocky). Low libido can become an issue in relationships when one partner wants sex more often than the other and this desire discrepancy can cause conflict and unhappiness.

What influences your libido?
Hormones:
Hormone levels can affect your libido. For example, breastfeeding women have an increased production of prolactin, which can reduce sexual desire, and women who have reached menopause experience a reduction in sex hormones, which can reduce libido.

Other causes of SD…

- Partners sexual function
- Libido mediated by LH and testosterone
- Enhanced or modulated by dopamine and serotonin → loss of desire: SSRIs
- Diabetes
  - Neuropathy (nerve damage) can reduce vaginal lubrication in some women
  - ED in men
  - Affect libido
  - Vaginal infections in women
  - Fatigue

Medications Effect Sexual Function

- Antihypertensives
  - Beta blockers
  - Thiazide diuretics
  - Methyldopa
  - Clonidine
- Psychiatric Medications
  - Antidepressants—amitriptyline, doxepin
- Antipsychotics—
  - phenothiazines, haloperidol, benzisoxazole (Risperidone)
- Recreational Drugs
- Alcohol
- Heroin
- Antiandrogens
  - Gonadotropin-releasing hormone agonists
  - Estrogen-containing medications
- Cimetidine (in very high doses)
- Ketoconazole
- Spironolactone
- Antiarrhythmics
- Disopyramide
- Digoxin

Gynaecological Cancer Sexual Morbidity

- Gynecological cancer assoc with higher rates of sexual morbidity
- Poor psychological adjustment or impaired QoL
- Treatment-related sexual morbidity can be anticipated
- Should be addressed in a timely fashion
- Sexual morbidity a lasting and distressing for a subset of survivors (Levin et al., 2010)

Post treatment sexual adjustment following cervical and endometrial cancer

- Interviewed 20 women age 19-64yrs
- Psychosexual issues integral but ignored aspect of QOL
- Ist year post treatment 50% ↓ of women reported sexual morbidity
  - ↓libido, ↓ arousal, ↓ orgasm, ↓lubrication , ↓sensation,
  - ↓vaginal elasticity, shortened vagina, vaginal atrophy, stenosis, cystitis, fistulas (Juraskova, Butow, Robertson, Sharpe, McLeod, & Hacker, 2003)

Post treatment sexual adjustment following cervical and endometrial cancer

- High levels distress coping with long term effects
- Unforeseen side effects- considerable distress & anger
- Reminder everyday
- Clinicians assumed women had greater knowledge of a & p than actually did
- Partners coping: reluctant to discuss feelings, concerns
- Partners afraid to resume intercourse, women interpreted this as rejection/ disinterest

(Juraskova et al., 2003)

Sexuality and the terminally ill

- Often not regarded as important by HCP
- Paucity of research
- Need or ability for sexual activity may wane
- Need for touch and intimacy may not wane
- Emotional connection becomes an important part of sexual expression
- Difficult to feel sexual when you are the caregiver
- Privacy issues when in hospital/hospice (Katz, 2007)

The Plissit Model (Anon, 1976)

- Permission- *women undergoing this procedure often have concerns or questions about sexuality. Is there anything you would like to discuss?*
- Limited information- *while you should not have penetrative intercourse until you have had your six weeks post operative check, it is fine to kiss and cuddle with your partnet. Don't worry if you become aroused… this is not harmful and will actually speed healing*
- Specific information- *If you find pentrative intercourse painful, particularly deep thrusting, you may want to try different positions; side-by side or you that you are on top. In this way you can control the depth and speed of penetration which will lessen the chance of you experiencing pain*
- Intensive Therapy…… *I would like to refer you to …..*
- Most concerns dealt with in first 3 levels
- Each stage requires increasing professional competence
- Gives permission to HCP to refer patient to someone else, if insufficient knowledge/ uncomfortable

Commom Questions

- Absent or deceased libido
- Dyspareunia
- Shortened vagina
- Impact of hysterectomy
- Fear of resuming sex
- Body image post vulval surgery

Learning from our patients

- ‘somebody should have said this is how you are going to feel about it…… and offered us some practical ways of dealing with it as a couple’
- ‘don’t look at myself anymore’
- ‘manage life without sexual intercourse, feeling lucky to be alive and grateful for the treatment’ (Hordern & Street, 2007)

Learning from our patients

- " I can't imagine anyone going through chemotherapy, and feeling like I did and the still wanting to rush home and have sex" …

  Partners need to understand that if she doesn't want to that's totally understandable…. Just sit down and talk and share your private feelings- that's a special thing to do. " Kate

  (Heffernan & Quinn, 2003)

Resources

- Dr Anna Fenton
- Social workers
- Cancer Society
- Relationship services
- Rosemary Smart
- NZ Sex Therapy
- Jean Hailes Foundation Website

Implications for Practice

- We need to ask the questions…along the journey
- Patients want
  - Information
  - Emotional support
  - Practical strategies
    - Provided in a manner that is timed to suit their individual needs

(Hordern & Street, 2007)

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