

## Chapter 35

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# Communicating about sexuality in cancer care

John W Robinson and Joshua J Lounsberry

Extensive research has shown that cancer, and the treatment thereof, can interfere with healthy sexual functioning. Indeed, sexual dysfunction is frequently cited as one of the top adverse effects of cancer treatment (1). However, while healthcare professionals routinely discuss quality-of-life issues with cancer patients, the literature suggest that too often this does not include an assessment of sexual concerns. One study reported that 96% of healthcare professionals stated that discussing sexuality was part of their job, while only 2% said that they regularly spoke to patients about sexuality (2). When questions incorporating sexual functioning were included in routine patient assessments, approximately 41% of patients indicated problems with sex (3). However, if patients are not asked specifically about sexual functioning, less than 10% will raise sexual concerns (4). Clearly, the responsibility to initiate discussion on sexuality rests with the healthcare professional.

Establishing the sexuality information needs of the cancer patient can sometimes be difficult and it becomes more so when healthcare professionals make erroneous assumptions concerning sexuality. Healthcare professionals often hold the belief that cancer patients are, and should be, most concerned with treating the cancer and that other considerations are tangential (5). In fact, some patients are willing to trade years of life to maintain sexual function (6). Further, healthcare professionals often believe that the responsibility for discussing sexuality lies with someone else, which often results in no one assuming the responsibility (7, 8). Even when the healthcare professional does accept the responsibility, there are a host of commonly stated reasons for not initiating the conversation, including: limited time; a lack of education; embarrassment; the feeling that it is not a part of the presenting problem; a preference for same-gender consultation; the sexual orientation of the patient; the assumption that sexuality is not a concern for either the very young or the older patient; and possible religious or language barriers (8–10). However, patients often express a desire to receive information regarding sexuality, and irrespective of patient age, sex, partnership status, culture, or site of cancer, patients have stated that their needs in this area often go unmet (5).

Unresolved sexual problems can have devastating effects on the lives of both the patient and their partner. These effects can range from mild embarrassment, unhappiness, and frustration to profound humiliation, loss of self-esteem, erosion of the relationship bond, and complicated mental health issues. Indeed, patients need information detailing how to stay sexually active for as long as they wish, in spite of their illness. Thus, whether or not to assess sexuality is no longer an issue; it must be a routine part of cancer care.

## The PLISSIT model

While there are several different models of intervention for patients suffering from sexual difficulties, the model known by the acronym PLISSIT is frequently used in cancer centres and can easily be adapted to various types of practice (11, 12). The model describes four progressive levels that can be used to guide assessment and intervention (13).

- ◆ **Permission.** Raise the topic of sexuality so that patients feel that they have permission to talk about sexual concerns.
- ◆ **Limited Information.** Provide information to address the sexuality concerns of the patient, including sexual sequelae common to their situation.
- ◆ **Specific Suggestions.** Taking into consideration their sexual history and relationship, provide specific strategies for dealing with problems and maintaining sexuality.
- ◆ **Intensive Therapy.** Refer to a specialist those patients who have premonitory sexual concerns, mental health problems, or those with more complex problems.

While the model is designed with a hierarchical structure, practically, it is not a tool to be used in a strictly linear fashion. There are many areas of overlap between each of the levels and, as different issues develop, the healthcare professional may be required to move back and forth between levels. The PLISSIT model should be used fluidly as a guideline to inform practice.

### Permission

Raising the subject of sex during the first meeting grants the patient permission to talk about their concerns and serves to legitimize the existence of sexual thoughts, feelings, and desires. Thus, granting permission should be implemented with all patients regardless of demographic variables or disease status, so that the choice of pursuing this topic is left to the patient.

The importance of addressing sexuality early is highlighted by findings that ignoring sexual dysfunction after cancer treatment can lead to erosion in the marital bond (14), self-concept, and social relationships (15). On the other hand, early intervention can lead to the resumption of sexual activity, which has been shown to enhance quality of life (16) and to increase the chances of optimal recovery of sexual function (17). Incorporating a generic question about sex into an initial history or follow-up visit can be an effective first step. These openings provide patients with an opportunity to ask questions and to indicate their level of sexual functioning. While the therapeutic benefit of the mere disclosure of personal information to a trusted healthcare professional has long been recognized (18), patients/couples may not want further discussion, so the issue should not be forced. The patient may wish to concentrate on their primary treatment or may not yet have concerns regarding sexuality. However, by granting permission the healthcare professional has let the patient know that it is a valid concern.

Questions to initiate discussion:

- ◆ What impact has cancer had on your sex life?
- ◆ Are you experiencing any loss of sexual function?
- ◆ Do you feel any different about yourself as a man/woman as a result of your cancer?
- ◆ Many people are concerned about how their illness will affect their sexuality. What concerns do you have?

Patient sexuality is more often overlooked when the sexual organs are not directly involved; however, there are a number of sexual side-effects to treatment that are common to most cancers (5). Patients often struggle with incontinence, hygiene, fatigue, pain, dependency on others,

and loss of earning power; all of which can adversely affect the patient's sense of sexual appeal. Following cancer treatment, most patients are also affected by changes in their perceived body image. In some cases the changes are intuitive such as alopecia, breast loss, ostomy, or laryngectomy. In other cases the loss is less obvious but nonetheless heartfelt: loss of body hair, uterus, rectum, physical strength, or stamina. Few patients are unaffected by such challenges, and thus the majority require information on sexuality regardless of the cancer site or type of treatment.

Some patients may be too young at the point of diagnosis or treatment to be engaged in sexual activity; however, given the ever increasing survival rates for cancer, the patient will likely become sexually active at some point in their lives. Thus, provisions must be made to ensure that the patient is informed of the likely effects of cancer/cancer treatment on both sexuality and fertility. On the other end of the spectrum are those who may be 'too old' or 'too sick' to be sexually active. The healthcare professional must remain aware of the fact that couples in their 60s to 70s still want to be sexually active (19) and that even palliative patients find comfort in sexual intimacy (20).

Relationship status is another important consideration when discussing sexuality. Whether or not the patient is currently engaged in a romantic relationship has bearing on the types of concerns that they are likely to have. Also, it is incumbent upon the healthcare professional to determine the sexual orientation of the patient, rather than assuming them to be heterosexual. This can be easily accomplished by asking the patient's relationship situation.

Finally, ethnic or religious diversity can become a factor. The healthcare professional should always remain aware of the part played by the cultural/religious assumptions of both themselves and the patient with regards to sexuality. That being said, while there are likely to be many differences in the desired method of communication, the types of sexual dysfunction after cancer are common to patients from all ethnic or religious groups.

### Box 35.1 Clinical example

Chris and Patti, a Canadian couple in their late-forties, had been married for 25 years and had become caught up in their busy life. Then, Patti was diagnosed with cancer and underwent an allogeneic stem cell transplant.

Everything was going well with regards to Patti's physical recovery at a 9-month follow-up, but there had been some changes in the couple's relationship. Both Chris and Patti reported having felt closer than ever during the crisis of initial diagnosis and primary treatment. However, now that Patti was out of the hospital and was doing well, things had begun to deteriorate. They had become frustrated with one another and had begun bickering over minutia.

I informed the couple that it is common for issues to arise once the threat of cancer subsides. Sometimes this uprising of issues can be related to the disruption in the level of sexual intimacy in the relationship and the uncertainty about resuming sexual relations. As it turned out, Patti was having concerns that Chris was no longer attracted to her, while Chris was patiently waiting for Patti to let him know when she was ready to resume their sexual relationship.

As we talked, the couple began to realize that the tension they had been feeling in the relationship was coming from the pent-up feelings they both had about this issue. The couple expressed relief and gratitude about finally breaking the silence around sexuality.

## Limited information

The next level of intervention is the provision of information pertinent to patient concerns. Although the healthcare professional may need to warn the patient that cancer treatment can impair sexual functioning, it is crucial to convey the message that sexual activity is not at an end. Patients may wonder if they can continue sexual relations during treatment, they may have concerns about changes in their body following treatment, or they may have concerns about satisfying their partner. Failure to provide information may lead the patient to expend needless emotional energy worrying about concerns that could easily have been allayed. It is also important to remember that the patient will likely feel overwhelmed when initially diagnosed with cancer and may forget much of the sexual information provided. Therefore, during follow-up visits, patients will benefit from being asked again about their sexual concerns and having them addressed.

Following primary treatment, the patient should be provided with resources outlining the lasting effects of cancer treatment in general, as well as specifics for their particular situation. Written information can be particularly helpful because it allows the patient to work with the material on their own time (21). Numerous reliable sources of written information are available for patients.

- ◆ Schover L (1998). *Sexuality and cancer: for the woman with cancer and her partner*. New York, NY: American Cancer Society.
- ◆ Schover L (1998). *Sexuality and cancer: for the man with cancer and her partner*. New York, NY: American Cancer Society.
- ◆ Cancer Council of Victoria (2004). *Sexuality and cancer: a guide for people with cancer*. Carlton, Australia: Cancer Council of Victoria.
- ◆ Canadian Cancer Society (2006). *Sexuality and cancer: a guide for people with cancer*. Toronto, Canada: Canadian Cancer Society.
- ◆ Schover L (1997). *Sexuality and fertility after cancer*. Toronto, Canada: John Wiley & Sons, Inc.

## Sexual response cycle

The sexual response cycle is a helpful model for explaining both sexual functioning and the ways in which various treatments will likely affect sexual functioning (22, 23). In addition to the diagram outlining the sexual response cycle (Fig. 35.1), patients often find 3-D models of pelvic

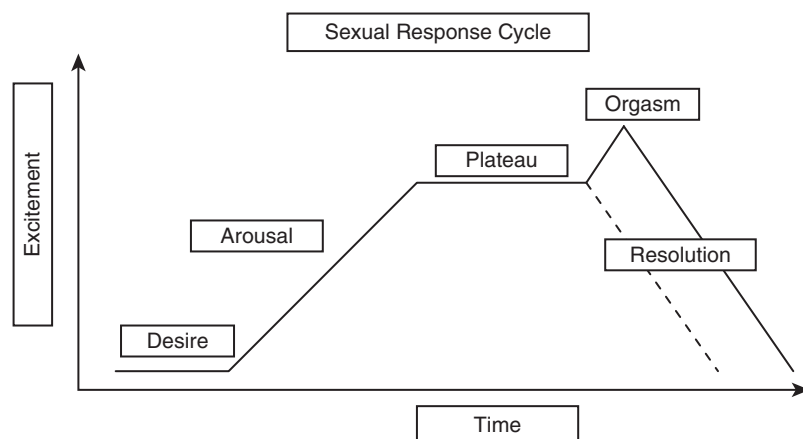


Fig. 35.1

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anatomy helpful when trying to understand the changes that are taking place at the various stages of the cycle.

The sexual response cycle is usually presented as a linear series of phases beginning with Desire. Desire is commonly experienced as sexual thoughts/fantasies or spontaneous sexual urges. When a person acts upon their desire they move to the Arousal phase. Lingering in a state of sexual arousal is referred to as Plateau, from which the sexual tension that is built up in the excitement phase can, with further stimulation, be released in what is called an Orgasm. There is, however, no imperative for a sexual encounter to culminate with an orgasm. The tension that builds during sexual play can be allowed to dissipate on its own without harm, and arousal can be enjoyed in its own right. The Resolution phase refers to the period during which the body returns to physiological norms. If the sexual experience has gone well, this is the phase where many couples experience the greatest emotional closeness.

### Revised sexual response cycle

Loss of sexual desire is one of the most common sexual effects of cancer treatment. Basson's (24) refinement of the sexual response cycle can be particularly useful in helping patients understand the changes that they are experiencing (Fig. 35.2). While in the past the revised model has been applied specifically to females, clinically it appears to have applicability to both female and male cancer patients. This model differentiates between spontaneous/innate sexual desire and receptive/responsive sexual desire. Spontaneous desire corresponds to the aforementioned conceptualization of the sexual response cycle beginning with Desire. Basson theorizes that desire often follows arousal, rather than precedes it. Thus, if the patient is motivated to engage in potentially arousing sexual activity, and if they begin to feel sexually aroused, desire will be triggered. The importance of enhancing motivation and understanding the patient's fears about engaging in sexual activity are highlighted in this revised conceptualization.

Many cancer patients find that the French axiom, '*L'appetit vient en mangeant*' or '*Appetite comes while we eat*' is one that captures this concept and resonates with their experience. Just as cancer patients commonly lose their spontaneous appetite for food, so too do they often lose their appetite for sexual relations. When the appetite is weak, the mere idea of being expected to eat an entire four-course meal is sure to stifle any willingness to taste the first course. However, if patients are gently encouraged to taste some food knowing that they can just nibble the bits that

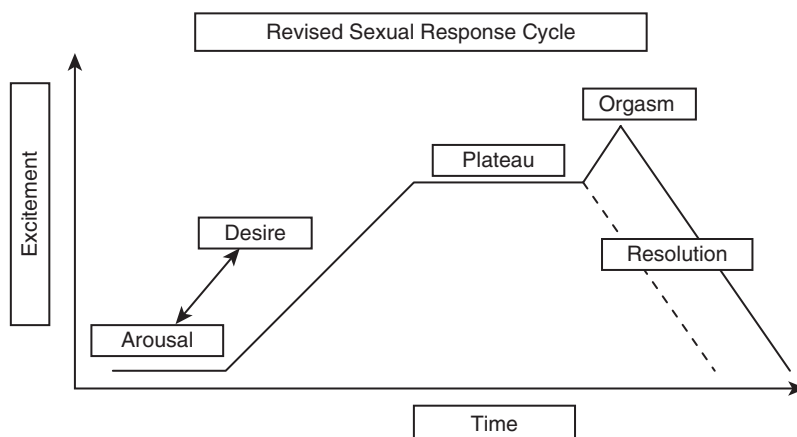


Fig. 35.2

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they find appealing, there will often be an enjoyment and a concomitant awakening of appetite. Similarly, many patients are more willing to engage in sexual touching when there is no pressure to reach climax or to engage in sexual activity that is not appealing.

### Resuming sexual intercourse

The sexual response cycle can be used to help the patient understand that the impairment of one aspect of sexual functioning does not preclude satisfying experiences in other aspects. For example, when a female patient has been instructed to refrain from sexual intercourse, she and her partner may be unaware that other sexual activity is a possibility. Similarly, after radical prostatectomy, sexual desire, pleasurable genital sensation resulting in arousal, and the ability to have an orgasm often are not impaired, even though the patient may experience erectile difficulties. For a man, arousal is usually palpable and there is often a direct association between the sight/sensation of an erection and a report of subjective arousal (24). Thus, when there is a loss of erectile function the man often overlooks the remaining subtle and less familiar sensations, making the erroneous conclusion that arousal is unattainable. This concept of orgasm without erection seems counterintuitive to most patients. Men will often find it helpful to have information on the physiology of orgasm, particularly with regards to the fact that the nerves that are involved in erectile function are different from those involved in sensation and orgasm. Analogies, such as those described in Box 35.2, can be an effective way of simplifying complicated concepts.

### Issues of fertility

Although fertility issues are most pressing for patients who still wish to have children, the ability to procreate can be an important part of a positive sexual image, independent of the

## Box 35.2 Helpful analogies

### Christmas light analogy

The Christmas light analogy can be helpful in explaining the phenomenon of orgasm without erection. Many men believe that they are wired like an old string of Christmas lights where, if one bulb burns out (the ability to have an erection), the whole string goes out. Further, there is the belief that if you cannot replace that bulb and regain the ability for erection, you may as well throw out the whole string because none of the bulbs will light. However, we know that men can, in fact, experience orgasm without an erection, so all the Christmas lights do not go out when one bulb burns out.

### Orgasm/sneeze analogy

It is sometimes instructive for patients to think of orgasms as pelvic sneezes. The tension in the face and the tickle in the nasal passages indicate that a sneeze is building. Likewise, for orgasm there is a build-up of muscle tension and congestion, in other words arousal. Sneezes can be stifled and the tension allowed to dissipate on its own, just as arousal can be allowed to dissipate without orgasm. While sneezes release the tension in the face, orgasm releases sexual tension.

To carry the metaphor further, we can have a wet sneeze if there is mucus in the nasal passages and dry sneezes if there is none. Similarly, men have wet orgasms—ejaculate—if they have a functioning prostate that produces seminal fluid and dry orgasm if they don't. Wet and dry sneezes feel different and yet they are both unmistakably sneezes.

### Box 35.3 Clinical example

Chris and Patti did have questions and concerns about resuming sexual intimacy, so the conversation continued on to these topics. Patti brought up the common concern of changes in how her body responds sexually. I informed the couple that these changes are quite common and that the loss of spontaneous desire is particularly common. When the idea of ‘our appetite develops as we eat’ was presented to the couple, they both found that it applied well to their situation. I also informed the couple that while women do have an awareness of the physiological sensations of arousal, it is the thoughts and emotions that she experiences that determine subjective arousal. If Patti were to embrace her perceptions of sexual feelings and thoughts, her arousal might be reinforced. Normalizing the situation reduced the couple’s anxiety and allowed Patti to look for solutions, rather than concentrate on the bodily changes. I also provided the couple with a booklet that contained an explanation of the changes that were likely following cancer treatment, so that they might review things on their own. While the couple was provided with the tools to resolve their issues, the door was left open to take the conversation further, if the couple so desired.

wish to reproduce (25). The loss of fertility can exacerbate the struggle to maintain a positive body image after cancer and can result in the feeling of being damaged goods. Given that chemotherapy and broad irradiation are likely to affect fertility, it is incumbent upon the healthcare professional to provide the patient with options for preserving fertility. Research suggests that, unless the healthcare professional takes the initiative to refer patients to a fertility specialist, it is unlikely that patients will go of their own accord (26, 27). For more information on this issue see Chapter 34.

### Specific suggestions

Attention to patient context is always important, but it is even more so when providing specific suggestions. While people across cultures, religions, and sexual orientations are more alike than they are different, it is important to remain aware that there may be issues specific to particular groups. Resources are available to help healthcare professionals become more sensitive to diversity issues (28–35). However, patients themselves are often more than willing to explain how their background and upbringing informs their sexuality and they often appreciate the healthcare professional taking the time to ask. The key is not to make an assumption about your patient because there are likely factors involved of which you are unaware. For example, the adoption of Euro-Canadian sexual attitudes and beliefs is often not related to length of residency but rather to acculturation into Western culture (36). That being said, many of the suggestions that healthcare professionals offer apply across cultures and sexual affiliations.

It is important to include partners in the conversation when providing specific suggestions. Partners often have concerns of their own, but can also play a vital role in helping the patient overcome any difficulties. It will be helpful to obtain a brief sexual history in order to understand the dynamics of the couple’s intimate relations (Box 35.4). The sexual history will also help to reveal the true source of the sexuality problem. If the patient states that they have lost desire, but the healthcare professional is unaware that they are experiencing dyspareunia, the root cause will have been missed and any suggestions to improve desire will likely fail.

### Box 35.4 Sexual function assessment questions

#### Desire phase

Are there times when you spontaneously experience desire for sexual activity? If so, how frequently?

If your partner approaches you sexually, how do you usually respond?

#### Arousal phase

How easy or difficult is it for you to become sexually aroused or excited?

Men: Do you ever experience difficulties obtaining or maintaining an erection?

Women: Do you experience a sense of pelvic fullness and find that your labia become engorged? Do you find that you lubricate or become wet?

Do you ever experience pain with sexual activity?

#### Orgasm phase

On most occasions, when you wish to are you able to reach orgasm?

Do you sometimes find that you reach orgasm faster than you want or that it takes longer than you would like?

Everybody is different in the types of stimulation that best help them reach orgasm. What types of stimulation work best in helping you reach orgasm?

#### Resolution

When you reflect back on your recent sexual experiences, how do you usually feel?

Are you concerned with any aspect of how your body responds sexually, with your sexual relationship, or your ability to be a good lover?

Another important contextual factor is the use of medications that interfere with sexual functioning. For example, depression is strongly associated with sexual dysfunction and the use of antidepressants often exacerbates the problem (37). More than half of those who take antidepressant medications, especially selective serotonin reuptake inhibitors, experience decreased desire, difficulties becoming aroused, and problems reaching orgasm (37). However, there are antidepressants (Mirtazapine, Moclobemide, Nefazodone, Reboxetine) that have been found to have limited negative effects on sexual functioning (37, 38) and Bupropion is reported to have actually improved sexual function for women treated for breast cancer (39). Switching to Bupropion has also been shown to be effective for men who are experiencing erectile dysfunction or delayed ejaculation (40). Clearly then, it is important for the healthcare professional to remain aware of the medications that the patient is taking and to intervene on their behalf if a change in medication would improve sexual functioning.

In order to become effective in the provision of specific suggestions, the healthcare professional will need to acquaint themselves with the sexual sequelae for the patient population in question. Describing the approaches to treating the sexual difficulties for all of the specific cancer sites is



beyond the scope of this chapter; however, there are sequelae that are common to most cancers. It is important to remember that it is rarely cancer itself that directly interferes with sexual functioning; rather it is the treatment that most often causes the problems. An understanding of the important advances in our knowledge of the mechanisms of sexual functioning and the effects of cancer treatments will be required for skilled intervention at this level. At the very least, healthcare professionals should be knowledgeable concerning the most common sexual sequelae; vaginal dryness and dyspareunia (painful intercourse), loss of desire, and erectile dysfunction.

### **Vaginal dryness and dyspareunia**

Vaginal dryness and female dyspareunia are common after chemotherapy and pelvic radiotherapy (41, 42). Oestrogen-replacement therapy (ERT) can be an effective treatment—possibly even for hormonally sensitive patients (43). Some findings suggest that localized forms of ERT, such as vaginal creams, pessary, or ring, can be effective in reducing vaginal dryness without significantly increasing serum levels of oestrogen in hormonally sensitive cancer survivors (43). However, combining pelvic floor muscle relaxation with water-based lubricants, vaginal moisturizers (t.i.w.), and vitamin E (100–600 IU/day orally or locally) is perhaps more effective in treating dyspareunia than hormonal treatment (42, 44–46). Non-hormonal polycarbophil moisturizing gel (Replens) has been shown to improve vaginal health and sexual functioning for women with a history of breast cancer (47) who are unable or reluctant to use hormone replacement therapy (48).

### **Loss of desire**

Another common problem is the loss of desire. Androgen replacement is often cited as the only real ‘cure’ for women who experience a loss in sexual desire after losing ovarian function (49). Improvements in sexual response have been shown with the supplementation of testosterone to high physiologic levels (50, 51). While androgen replacement has been considered safe by some, even in women with hormone sensitive tumours (52), many caution against its use (53). Men too, commonly experience a loss of sexual desire following certain cancer treatments. Androgen-deprivation therapy, a treatment for prostate cancer, often results in a physical incapability of experiencing a sexual response because of the castrate levels of testosterone.

Psychosocial variables are equally, if not more, important than hormonal variables in the subjective experience of desire (54). For example, there does appear to be some evidence that men are capable of a full sexual response despite castrate levels of testosterone (55, 56). Similarly, contextual and relationship factors were found to be more important than hormonal ones in a study of women who underwent surgical menopause (57, 58). Behavioural interventions, especially those addressing motivational issues, have shown promise, even for women with low androgen levels (24).

### **Erectile dysfunction**

Erectile dysfunction is the most common sexual problem for which men seek treatment (59). The majority of men treated for prostate cancer will lose the ability to obtain an erection sufficient for intercourse (15). Men having pelvic surgeries, such as cystectomy or anterior–posterior resection, and those receiving pelvic radiotherapy may experience erectile dysfunction as well. Health care professionals should be aware of the most effective interventions for helping couples maintain sexual intimacy despite erectile dysfunction (60). These high rates of dysfunction may decline in the future with the increased awareness of the benefits of early intervention. It has been shown that men who start the use of an erectile aid, such as a vacuum erection device or phosphodiesterase-5 inhibitor medication, soon after radical prostatectomy or cryoablation improve their chances of recovering erectile function (61–64). Early use of erectile aids has also been shown to preserve penile length after primary treatment (62).

### Sensate focus

Sensate focus exercises provide a safe and comfortable framework through which couples can begin to explore sexuality with sensual touch. Couples learn to focus on the feelings that arise as they are pleasuring their partner and are being pleased, without the expectation or pressure to become aroused or engage in activities that are anxiety provoking. Special consideration must be given to the cancer patient because they are sometimes self-conscious about their body due to weight loss, scarring, or an ostomy. The patient is encouraged to start with what is comfortable for them, and to proceed at their own pace. There are materials available to help healthcare professionals to implement this strategy (65, 666). Brotto and colleagues (36) have found that training in mindfulness also helps women stay focused on sensual feelings and improves their sexual function.

### Intensive therapy

Research has shown that 80% of cancer patients' sexual concerns can be managed by intervention at the first three levels of the PLISSIT model (68). Nonetheless, the healthcare professional should be able to recognize the point at which the patient/couple should be referred to a specialist. Intensive Therapy is needed for patients with more complex medical problems or if there are relationship or attitudinal factors that impede their ability to use the information or suggestions. A history of poor psychological coping, sexual or physical abuse, chemical dependency, or previous sexual dysfunction are also associated with an increased propensity for major sexual difficulties (11).

The healthcare professional may also be faced with compliance issues following the provision of specific suggestions. It has been repeatedly shown that merely recommending that women use vaginal dilators to prevent vaginal stenosis after pelvic radiotherapy results in very low compliance rates (69, 70). Likewise, the advent of phosphodiesterase-5 inhibitor medications have led some to believe that erectile dysfunction is now easily treated. However, a recent review of the literature (15) found that 50% of men stop using the aid within a year. Most concerning are the patients who, when medical treatments do not seem to work, withdraw from all intimate

### Box 35.5 Clinical example

The tone of the conversation suggested that both Chris and Patti would be open to moving beyond limited information into the provision of specific suggestions. I provided the couple with instructions on the use of sensate focus techniques and encouraged them to try. If they started slow, with no intention of sexual intercourse, Patti's appetite might slowly start to develop. Both Patti and Chris agreed that this would be a good solution. The couple was also provided with a water-based lubricant, and were told that following a stem cell transplant many women do experience labial and vaginal dryness. I also asked the couple to report any vaginal stenosis—which is common after a stem cell transplant—because there are effective treatments available (67)

When I next saw the couple I could immediately see the difference in how they were relating to one another. When I commented on the change, they explained that the sensate focus exercises had provided them with a comfortable way of reconnecting physically and emotionally. They had come to the realization that while sexuality is not the glue that holds them together, it is the lubricant that helps smooth out the rough patches.

### Box 35.6 Clinical example

Although it was unlikely that the couple needed intensive therapy, I made sure that they were aware that seeing a specialist was possible and not out of the ordinary. I pointed out that, if left to their own devices, couples often avoid talking about sensitive issues because they are afraid of making matters worse. Couples who do seek professional counselling improve their chances of maintaining or improving sexual intimacy because it can help couples to have meaningful discussions about difficult issues and to express pent up feelings.

contact and become despondent. A more intensive intervention may be required to ensure optimal recovery of sexual functioning through compliance with treatment. In the previous example of the use of vaginal dilators, the information motivation behaviour model has been proven more effective than simply providing information (69). Biopsychosocial interventions also seem to increase the likelihood of remaining sexually active (71). However, these types of intervention are best left to those who have been professionally trained in their use.

### Reflecting on practice

Just as patients have a right to know if treatments will result in hair loss or nausea, so too do they have a right to know the ramifications of treatment on their sexuality. Rather than perpetuating the culture of silence around sexuality, healthcare professionals can work to improve or maintain sexual health. Most patients' needs are easily met through the normalization of thoughts and feelings, the presentation of accurate information, and the provision of appropriate suggestions. For more complex issues, the healthcare professional simply refers the patient to a specialist. Proficiency in communicating about sexuality with the cancer patient requires little more than knowledge of sexual sequelae of the cancer in question and a willingness to initiate the conversation.

Clearly, healthcare professionals endeavour to provide the best possible care. Thus, as conscientious healthcare professionals, we must ask why sexuality is so often overlooked when its importance has been repeatedly demonstrated. Our intent in these pages was to provide a tool to facilitate communication, while inviting a critical appraisal of the healthcare professional's beliefs, assumptions, and stereotypes. The hope being that healthcare professionals will reflect on the manner in which their context affects practice; that is, to base practice on evidence rather than assumption and to assign priority to the patient's wellbeing.

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