Women's Sexual Health Journal

Editorial

Last year I was diagnosed with breast cancer and my very first concern was treatment and survival, but in the process of researching all my options, sexuality issues slapped me right in the face when I was filtering through all the material I was given. I received Judy Kneece's book, Your Breast Cancer Treatment Handbook, along with a stack of other material. The only resource that I received that discussed sexuality issues was Judy's book. The American Cancer Society material did not address it, or any of the other material I received.

Before deciding on what chemotherapy treatment and surgical procedure I would have, I discussed how the treatments could impact me physically, including from an intimacy perspective. I wanted to know EVERYTHING. I recall one nurse who was reviewing chemo with me. Without any prompting from me, she stated most women do not want to discuss sexuality issues at this time, but I said I wanted to. My husband and I felt we had to make it clear to the team what was important to us. I wanted to continue working and I wanted to maintain as much quality of life post -cancer as pre- cancer. My doctors respected that and appreciated knowing that. They were great to work with and they are having their 12th annual regional breast cancer symposium this year. Guess what? They are including the topic of Rekindling Sexuality After Breast Cancer to be presented by Mary K Hughes, MS,RN,CNS from M.D. Anderson.

I have found that the vast majority of doctors will address questions involving intimacy and sexuality concerns as they relate to cancer and its treatment, and we women should not be afraid to raise them. After all, we fought for the right to have reconstructive surgery paid for by insurance companies, because it was important to many women. We fought our way through cancer treatment. If we can do that, we can certainly discuss ALL of our concerns with our doctors. Let's face it, we have been warriors at times. If you have intimacy concerns—ASK!

Lisa Martinez RN/JD, Executive Director, TWSHF

I can't imagine that it has escaped anyone that October is National Breast Cancer month, or from statistics such as the National Cancer Institute's estimate that 12.7% of women born today will have breast cancer. In a way, we are all survivors of breast cancer, because nearly all of us have been touched by it. Even if you have not had breast cancer yourself, surely you know someone—a relative, a friend, neighbor, or co-worker—who has.

Over 40 years ago, when my beloved grandmother Rita died, I was told it was because she was a smoker; no one dared say the word "cancer." Times have changed in this regard, and for the better, not only in terms of treatment advances but our attitude. Many cancers are now considered chronic diseases; treatment is for managing symptoms, rather than palliative, end-of-life care. I can't help but think that women having the courage to openly speak about their experiences have given researchers, physicians, and fellow women the incentive to keep looking for better ways to prevent, fight, and one day cure breast cancer.

Still, with all the advances and open communication, there is a reticence among older women to talk about their experiences. They may feel they have already burdened their partner with their illness and don't wish to ask for help when it comes to sex. And we know that people who work in the field of oncology still need to be educated about approaching their patients' sexual concerns, so sometimes little help is available even when a woman may have such issues on her mind. Health practitioners and their patients are

(continued on page 2)

Table of Contents

Editorial ... 1
Intimacy and Sexuality after Cancer ... 2
Cancer and Sexuality ... 4
Woman to Woman: Cancer and its Impact on Female Sexuality and Intimacy ... 8
Announcements ... 10
Calendar for 2008 ... 11

Published four times yearly by The Women's Sexual Health Foundation, Cincinnati, Ohio. The Journal (WSHJ) is an educational service to provide valuable information to professional, student, and public members of the Foundation. Founded in April of 2003, and directed by Lisa Martinez, RN, JD, The Women's Sexual Health Foundation (TWSHF) is a nonprofit corporation. TWSHF supports a multidisciplinary approach to the treatment of sexual health issues and serves as an educational resource for both the lay public and healthcare professionals. The Professional Advisory Board: Yitzchak (Irv) M. Binik, PhD, David Ferguson, PhD, MD, FACCP, Jean Fourcroy MD, PhD, Marjorie A. Green, MD, MPH, Woet Gianotten, MD, Andre T. Guay, MD, FACP, FACE, Susan Kellogg-Spadt, PhD, CRNP, Michael L. Krychman, MD, FACOG, Talli Rosenbaum, PT, PhD, Lynne Shuster, MD, FACP, Mitchell Tepper, PhD, MPH, and Beverly Whipple, PhD, RN, FAAN.

Articles, letters, and questions may be submitted to Dr. Stephanie Buehler, at info@twshf.org.

at a standstill; both need to talk, but no one is quite certain who is to start the conversation. Since health practitioners are the ones able to normalize a woman's experience and have access to more information and interventions, it seems that it is up to them to get the conversation going.

Of course, it is hard for most of us to talk about sex, so we cannot blame health care practitioners for having difficulty broaching the subject. In a world where sex is either something to abstain from or something to titillate, it is not really a surprise that most adults are clueless when it comes to sex. Sex education isn't just about how babies are made, or how STDs and pregnancy occur and are prevented. Sex education also means giving us all permission to talk openly about sexual experiences and sexual challenges without fear of embarrassment. That way, when anyone has a challenge, for any reason, they would know that not only is it okay to talk about it, but to get good information and help.

In this issue of the Women's Sexual Health Journal, we have two articles by psychotherapists who work with women with cancer, Sage Bolte, MSW, LCSW, OSW-C and Peggy Lipford McKeal, Ph.D. LMHC. Each author gives us a close up view of the sexual issues with which women with breast and other women's cancers commonly struggle, and each will hopefully inspire women, their partners, and practitioners to talk about sex.

Editor—Stephanie Buehler, MPW, PsyD, CST

Intimacy and Sexuality after Cancer

Peggy Lipford McKeal, Ph.D. LMHC

We may define personal intimacy in relationships as a mutual detailed knowledge, a deep understanding that has an explicit quality of being completely at ease, familiar and totally comfortable with one's own body, thoughts, wishes and desires, and inclusive of unrestricted communication interchange with our lover. We can include possible definitions of personal sexuality as our interest in sexual interaction, our own sexual character, and the ability to passionately surrender. Those are unique and sought after qualities in healthy relationships.

However, conversational topics focused on intimacy and sexuality are often difficult topics to discuss with anyone, including a partner, under perfectly normal circumstances.

Moreover, after diagnosis, possible surgery, chemotherapy, and radiation, women recovering from breast or gynecological cancers face the possibility of the necessity to seek out information from others about how to be sexual again in ways that are comfortable for them. It is often part of daily life for them to speak with various doctors, nurses, social workers, and others in the treatment team about their specific and general health. It is typical for these health practitioners to discuss everything but sexual health and they do not bring up the topic of a woman's sexuality and her relationship intimacy with her loved one first. They normally leave it to the woman to ask. The medical community, focusing on illness and improved health, does not treat pleasure or its deficit.

Women may find that they are also facing an embarrassing dilemma because they have a lover who is also living with the results and consequences of the diagnosis of her cancer. If individuals have not been able to be completely open and honest with their lover before, and they must do it now, the difficulty of speaking about the topics of sex will be compounded for the survivor and her lover. Often lovers of survivors don't broach specific subjects either, and are simply left with the uncomfortable feeling of not knowing how to do things now or what is okay in this newly defined world. Many couples, whether they are heterosexual or homosexual, may have never actually talked about sex, have never truly been intimate about their bodies and their feelings about them, or about their sexual wants and needs. How will they find the voice to speak about this topic now when there are so many new issues?

In a Gynecological Cancers Support group that meets one Thursday night a month, this and other topics are discussed. Women express when asked soon after diagnosis that sexuality and intimacy are the farthest things from their mind. They clearly state they have no interest and are focused on the traumas and dilemmas of treatment, be it surgery recovery, chemo, radiation, or combinations of those, and just getting through each day. Women in that support group and in an online discussion group about ovarian cancer report fatigue, poor body image due to weight gain, pain or fear of pain, vaginal dryness, decreased skin sensitivity, and reduced arousal and reduced orgasmic potential as just a few of the physical sexuality dampers. Other reported stressors are numerous. Concerns about finances that the treatments have caused, worry about their loved one and how that loved one is coping, routine daily chores that go by the wayside, lack of interest in most things due to depression and worry, lack of sleep, time constraints due to appointments, family problems that the diagnosis and treatment have caused, and anger about their diagnosis, are only a few. Some women discuss the continual subtle background thought of the possibility of and fear of recurrence of cancer. All agree that sexuality can find its way to the bottom of the list in priority.

Some women in each group as they are farther out in recovery time, admit that they are concerned about their lover needing and wanting that sexual and

(continued on page 3)

intimate part of the relationship back. Some admit feeling guilty that their own sexual interest still isn't higher or more prioritized. A few of the women in both groups have been able to discuss how hard it has been for them to talk about sex with lovers and medical professionals in attempts to find out how to improve phase-one-desire in which they fantasize and think positively about sexual interaction again. They report feeling not only a sense of obligation to their relationship, but also a sense of wanting-to-want. It is not that they are disinterested, they say, but that they are now just not interested.

Many of the women report the discovery that hormonal loss has essentially eliminated libido and decreased orgasm potential, and that, although they may still be orgasmic, it is greatly reduced and not satisfying. They report that they were not informed that surgery and treatment would probably change the sexual area of their life in this way forever. Some have stated that even though they have estrogen positive cancers their medical community offers hormone replacement therapies to help cope with the sexual anomalies caused by surgery and treatments. The women in both groups report confusion, anger and fear regarding the choice of hormone replacement. In addition, they admit those three emotions plus inability to understand and make a satisfactory plan of action retards desire for sexual contact. In each group, women are eager to hear that there is hope and that there are techniques, skills and actions that can improve and often help toward solving the problems. They eagerly seek each other for experience and advise.

Some of the women have generously offered advice and support about how they cope with many of the daily and ongoing concerns reported here. All gave permission to use their thoughts in this article as long as their identity remained anonymous. Mental health therapy and speaking with a clinical sex therapist are always discussed as good choices when there is depression, anger and grief that affect sexuality and intimacy. Naps to help cope with fatigue, and accepting the help of others who would give it freely or if asked is suggested for chores that don't seem to get done. Doing chores a little at a time and making them less important is also considered important. Focusing on the present, on gratitude, hope, and good personal health seemed to be a mantra the women offered who admit they worry about the future and about concern for others. Finances appear to be a burden and concern for them all, however they suggest to each other alternatives in pharmaceutical costs, requesting medication samples, the possibilities of help from Medicaid, Medicare, and speaking to health professionals about reductions in fees. Nearly all of the women who join in these groups or discussions have positive things to advise and focus on the positive as much as possible. When it comes to return of, or reclaiming of their sexuality, they suggest to each other, patience, time, and to keep trying even if it is just a little at a time in small steps toward new definitions and experiences of intimacy in their relationship.

In regard to gynecological cancers there is normally significant reduction of sensitivity due to hormone loss, and also to dissection of the numerous and complicated nerves and blood flow apparatus that surround and connect the pelvic erogenous zones, the vagina, cervix, clitoris, pelvic floor muscles, and other areas of the genital structure. Women who have experienced this loss of sensitivity suggest allowing time to heal the areas affected, and focusing on adjacent areas that remain sensitive. In example, one woman offered a complaint similar to those who have a mastectomy scar, about the scar on her abdomen and the surrounding area being numb. She stated that her stomach had previously produced arousal if lightly stroked by her lover and now she had lost feeling there that was pleasurable. She stated that the dead or prickly odd feeling included the crown of the vulva, or mons pubis. She reported with dismay that no one warned her that might be a side effect of surgery. Advice was given, by another survivor, for a feather or fur to be used in all adjacent areas away from but near to the scar tissue on the abdomen so that the woman could discern exactly where it now felt good to be touched lightly. It was suggested that a light small vibrator could also be used, away from the scar, to produce a little more sensation in areas that are currently less sensitive.

Women also discussed radiation destruction in gynecological cancer treatments. They reported that the vaginal walls were damaged in terms of elasticity, sensitivity to pleasure, and atrophy producing tearing and bleeding after penetration, burning sensations, loss of natural lubrication, and excessive tightening of the vaginal opening or introitus. Those who are more experienced discussed coping with these problems by using over the counter lubricants, graduated silicone dilators that can be prescribed by a physician and covered by insurance, and they even suggested use of penis shaped vibrators, dildos or sex toys to simulate intercourse and practice penetration. Some say that these can help reduce the anxiety associated with the fear of not being able to experience penetration with ease again. A survivor noted playfully, "If you can do it with a toy, you can tell you can do it with the real thing!"

Women who have been diagnosed and treated for gynecological cancers are a unique group in terms of difficulties with intimacy and sexuality. Although sexuality is a full-body experience, and breast cancer survivors experience many of the concerns mentioned here, intercourse is generally considered the most intimate and sexual of all experiences. Traumas to and diseases of the body that cause difficulty, embarrassment and anxiety specifically in regard to penetration or intercourse with a partner can alter a fundamental sense

(continued on page 4)

of self for women. Women who were interviewed agreed that education about the likely side effects to sexuality prior to treatments should be a priority in every office associated with oncology treatments. Knowing that there may be adverse sexual side effects but that there are techniques that can be used to return things to a more normal state, would give women hope as they experience recovery. Sexuality topics deliberately included in support group talks open the door to more relaxed discussions, less embarrassment and offer the opportunity to share solutions like the ones women have offered here.

Cancer and Sexuality

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Cancer survivorship rates are increasing significantly, shifting the focus of oncology care from just managing the disease and treatments to identifying the psychosocial needs of patients with the goal of directly improving quality of life issues (Tan, Waldman, Bostick, 2002; Helgeson, 2005;Katz, 2005;Zabora, BrintzenhofeSzoc, Curbow, Hooker, Piantadosi, 2001). Approximately, 10 million people are living with the effects of cancer, and 40% to 100% of these individuals will experience some form of sexual dysfunction (American Cancer Society, 2007; Derogatis & Kourlesis, 1981). Sexuality and intimacy are quality of life issues impacted by cancer and its treatments, regardless of age, race, gender or socioeconomic background (Shell, 2002; Katz, 2005; Zabora, 2004; Derogatis, 2000). Sexual dissatisfaction, whether physical, psychological or emotional, not only impacts the person being treated for disease, but also their partner and overall relationship (Svetlik et al., 2005). Although there is substantial literature supporting the experience of sexual problems in persons with chronic illness, like cancer, there is a significant lack of evidence-based sexuality assessments and interventions (Fronek, et al. 2005; Shell, 2002; Haboubi & Lincoln, 2003).

Chemotherapy, radiation and surgery are the common treatments utilized to treat cancer and often impact a person's physiological, emotional, psychological and sexual well being (Schover, 1999; Hughes,2000; Pelusi, 2006). Cancer treatments not only impact the physiological, but also heighten areas of distress like pain, fatigue, depression and anxiety (Zabora et al., 2001). Unfortunately, many treatments used to manage the distress of depression, pain or anxiety also create significant changes in the sexual response cycle, complicating or exacerbating symptoms of sexual dysfunction (Pelusi, 2006; Ananth et al. 2003;Frumovitz et al., 2005;Spagnola et al., 2003; Hughes, 2000).

Cancer survivors often experience "long term changes and obstacles, such as impaired immune response, vital organ dysfunction, hormone changes resulting in infertility, altered sexual function, cognitive changes, ongoing fatigue, depression, anxiety, family distress and economic challenges, to mention only a few" (Curtiss & Haylock, 2006) p 4.

All of these changes have the possibility of impacting a woman's perception of her self and how she gains meaning of her world, experiences, and new limitations brought on by the cancer and its treatments.

The Woman with Cancer and Sexuality

More than 2.1 million U.S. women are breast cancer survivors (NCI, 2006). Cancer treatments can have a profound impact on a woman's physical, cognitive and sexual function (Sunga et al., 2005). Sexual dysfunction has been said to impact 21% – 39% of breast cancer survivors and may be higher for those on hormone treatments (Goldstein & Tang, 1991;Ganz et al., 1998; Broekel et al., 2002) and even higher for women diagnosed with gynecological cancers. Cancer treatment options consist of surgery, chemotherapy, radiation and hormonal therapy (i.e. Tamoxifen or Aromotase Inhibitors). Combinations of the cancer treatments are dependent upon multiple factors like the tumor size and type of cancer but all cancer treatments have side effects and the possibility of impacting the sexual esteem and function of a woman (Table 1).

The impact of cancer and its treatments on a woman's sexuality are significant. Side effects like pain and fatigue often impact a woman's sexual function, sexual identify and feelings of attractiveness (Hughes, 2000; Zabora, 2003). Estrogen antagonist treatments (i.e. Tamoxifen) for women who are estrogen receptor and progesterone receptor positive complicate sexual function and a woman's sexual esteem due to the medically induced menopause (Henson, 2002). Many of these physical side effects impact a woman's sexuality both covertly and overtly, as seen in the expression of the sexual self. Lowered immunities, lack of energy, appetite changes, bone and muscle ache and changes in physical appearance can lead to changes in intimate relationships. Women report feelings of guilt for not being able to maintain their many roles as mother, wife, partner and employee (Spagnola, et al., 2003; Devita, Hellman, Rosenberg, 1985). Partners are often timid about initiating sexual contact out of fear of hurting her or being perceived as selfish (Mayo Clinic, 2006; American Cancer Society, 2006).

Ovarian androgen production commonly stops (although it may return) with chemotherapy, as well as with radiation to the gonadal areas or to the pituitary gland. Androgen loss can create multiple problems for

(Continued on page 5)

the subjective pleasure, arousal and desire and sexual function experienced by a female cancer survivor (Graziottin & Basson, 2004). Androgen loss impacts the biological function of sex, but the loss of desire, arousal and orgasm can also impact the psychological and emotional responses to the change in sexual function.

Cancer treatments and their side effects can have a profound impact on a woman's sexual physiological response cycle such as desire, arousal and orgasm, which can impact the cognitive, emotional and behavioral responses (Shell, 2002; Pelusi, 2006). What a woman thinks about herself, how she feels about herself, her behavioral responses, intimate and sexual relationships all impact her sexual self. Her sexual self impacts the ways in which she then interprets the sexual consequences of her cancer and its treatments. Some women may be able to adjust without distress to the change in their sexual desire and function, and others may experience increased distress, depression or anxiety which then indirectly influences sexual function. Increased distress around the diagnosis itself can influence sexual function and how the sexual self responds or reacts to the many physical, emotional and psychological changes that he/she will experience during and after treatment (Zebrack et al., 2004). When distress is high, sexual desire is low, and therefore, sexual response is challenged (Graziottin & Basson, 2004).

Women with cancer often have some form of disfigurement from surgery, stem cell transplant (scarring from graft versus host disease) or radiation treatment that alters the integrity of the breast shape and tissue or other areas of the body that may or may not be externally visible to the practicioner, such as a colostomy. Loss of physical sensation around the nipple and skin surrounding the breast is a common side effect of treatments for women with breast cancer. Women who have had surgery or received radiation to the pelvic or anal area may experience significant vaginal dryness, bowel and bladder problems, vaginal and anal pain or discomfort. Lack of sexual stimulation of the breast has been identified as an emotional stress as well (Shell, 2002) and can impact the sexual response cycle of arousal. Some women experience medically induced menopause from the chemotherapy or removal of the reproductive organs, which results in infertility and decreased libido for many. The inability to conceive can be very distressing for some women. Libido changes can impact a woman's relationship as well as her perception of herself as a sexual being. Loss of all bodily hair as a result of chemotherapy could impact a woman's perception of her self and self esteem. Weight gain often caused by the pre-meds (i.e. steroids) administered with chemotherapy, as well as the hormone replacement therapies can impact a woman's perception of her sexual self. A new phenomenon known as "chemo-brain", which can be described as difficulty with short term memory, learning new tasks and word searching, can also be distressing to a woman and how she perceives her ability to interact with her work, children, friends and family (breastcancer.org, 2002).

Cancer is not prejudice of age or race as it affects diverse groups of women from many socio-economic backgrounds. Taking a cognitive-integrative approach, how the woman responds to the diagnosis and the changes in her sexual function are likely due to the experiences she had in her life and how she continues to make meaning of the experiences in the present. A woman's relationship status, previous sexual experiences, self-esteem, physical health, resources, and understanding of cancer and its impact on sexual function all impact the woman's sexual self – positively or negatively.

Common areas of physical distress like fatigue, libido changes, vaginal dryness, hair loss, weight loss and weight gain, and pain, as well as the emotional distress of anxiety and depression not only have the potential of impacting a woman's sexual self but, as will further be examined, her sexual self could impact the level of distress experienced. If we as sexual health practitioners are to assist women with cancer improve their quality of lives, especially as it relates to their sexual health it is important to understand how her cancer and its treatments, as well as the meaning that she makes from her cancer experience impacts her sexual self.

(Continued on page 6)

TABLE 1

Side Effects of Cancer Treatment

Surgery	Chemotherapy	Radiation
Mastectomy: Removal of breast. Loss of nipple & sensation of breast.	Treatment induced menopause: hot flashes, temporary or permanent infertility, weight gain.	Skin irritation and pain.
Bilateral Mastectomy: Removal of both breasts. Loss of nipples and sensation of breasts.	Weight gain or weight loss	Skin sensitivity and or lack of sensation.
Lumpectomy: Removal of tumor and surrounding breast tissue. Can create loss of feeling in some areas around the breast. Changes shape of breast.	Decreased libido	Fatigue
Lymphedema: Side effect of the removal of lymph nodes during surgery. Resulting in swelling of the arm, breast or leg which can interfere with previous sexual routines.	Vaginal dryness	Can create cardiac/respiratory problems that can impact sexual functioning.
Hysterectomy: Often removes the uterus, cervix, ovaries and fallopian tubes. Resulting in medically induced menopause and changes in vaginal integrity.	Vaginal stenosis: narrowing of the vaginal canal which can make sex painful if not appropriately stretched.	Bowel changes if radiated in pelvic area, causing great discomfort and incontinence. May lead to sexual withdrawal if concerned about incontinence.
Ostomy/Stoma: A surgically placed opening in the body to allow for basic bodily functions to continue. Often a bag is attached to the site to allow for the collection of fluid/ waste. Or a trach placed in the windpipe to help with speaking/ breathing.	Skin changes and neuropathy (tingling of hands and feet) common.	Extreme vaginal dryness, possible scar tissue development and vaginal stenosis if radiated in pelvic area.
	Hair loss including eye lashes, eye brows, pubic hair.	Vaginal stenosis or scar tissue can lead to sexual aversion if sex had been attempted and pain occurred.
	The integrity of the vagina changes and the vaginal wall thins, which can create some spotting during sex.	
	Common somatic complaints that interfere with sexuality: fatigue, nausea, joint and muscle pain, sleep disturbances, neuropathy	
	Cardiac problems	
	Lowered immune system making her more susceptible to infections.	
	"Chemo Brain" – a commonly noted cognitive change in the ability to remember and retain information.	

(Continued on page 7)

WEBSITES & RESOURCES:

Information & Support (Fertility and Sexuality, Chat Rooms, Blogs, Resources)

www.cancer.gov/cancertopics/pdq/supportivecare/sexuality NCI Sexuality and Reproductive Issues (PDQ) Health Professional Version:

www.gayhealth.com LGBT information and support

www.faceit.org Resource for people affected by facial disfigurement:

www.ulmanfund.org A resource for young adults with cancer

www.planetcancer.org A resource for young adults with cancer

www.realtimecancer.org A resource for young adults with cancer, based in Canada

www.cancerbackup.org

www.fertilehope.org A resource on fertility information and support

sexsupport.org/index.html Variety of discussion, chat and resources for multiple 'disabilities', including the LGBT community

bccpd.bc.ca/i/pdf/WDI/Sex_DisabilityWebliog.pdf

Sexuality and Disability Webliography (videos, devices, books, etc).

More detailed information can be found in *Sexuality for Women and Their Partners* and *Sexuality for Men and Their Partners* written by the American Cancer Society online at www.cancer.org. A printed version of these documents -- available in Spanish as well as English -- may be ordered for free by calling 1-800-ACS-2345. To find more information about fertility options see the American Cancer Society's document *Fertility and Cancer: What Are My Options*. You can also find information through the nonprofit organization Fertile Hope, at 1-888-994-HOPE.

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Woman to Woman: Cancer and Its Impact on Female Sexuality and Intimacy

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I founded The Women's Sexual Health Foundation in 2003 to bridge the gap due to the lack of information in the area of women's sexual health disorders that existed for women and healthcare providers and educators.

I was diagnosed with breast cancer in 2007. It was not until I was given Judy Kneece's book *Your Breast Cancer Treatment Handbook* at the time of my diagnosis and came to the chapter on Sexuality After Breast Cancer did it strike me that cancer would impact my entire being, including possibly sexual function. When I first heard the words "you have breast cancer", concerns about body image and intimacy were not at the top of my list. Saving my life was.

For many, cancer is a chronic disease. As with any chronic disease there can be an impact to one's quality of life. But when I came across the sexuality section in Judy's book, I realized that not only would I loose a breast, there were so many ramifications to the surgery and the treatments to follow.

I was fortunate because I knew Judy and instantly e-mailed her for wisdom. Also I had access to the world's experts in sexual health. Many are on The Women's Sexual Health Foundation's Advisory Board. However, I am acutely aware that not all women have this type of access and that is why I felt compelled to write this article.

Reclaiming Intimacy

Life does change after cancer, but that does not mean women cannot reclaim many aspects of the quality of the life they had before cancer. One area that is often not discussed with cancer survivors is that of sexual function and intimacy. A survivor may wonder if surgery or radiation or various cancer medications may impact the intimacy she once had. These are important questions and she has every right to have them addressed by her physician.

One out of three women will have cancer in her lifetime. Cancer and cancer treatment such as chemotherapy, radiation, surgery and hormonal therapy can impact a woman's ability to enjoy sex. Plus, many of the procedures are very intrusive and after being poked and prodded over several months, the last thing that may be on a woman's mind is any form of intimacy. Research shows that approximately 90 percent of those who have had cancer will have difficulty with sexual function. You are not alone if you have intimacy difficulties since your cancer diagnosis and treatment. So if you have a concern, you should raise it with your healthcare team. If your doctor cannot help you, then ask for a referral to someone who can. More and more healthcare professionals are developing the expertise to help women with sexual function and intimacy difficulties.

Why Does Cancer Cause Sexual Difficulties

There may be various reasons why sex may not be enjoyable after cancer. There can be emotional and physical reasons. Cancer is stressful for many to manage from a financial, relationship, family and employment perspective. Day to day life for many women is filled with plenty of stress, but when the diagnosis of cancer and its treatments are added to this

(continued on page 9)

mix, the stress can be overwhelming. This stress can interfere with one even considering having an intimate relationship.

Certain surgical procedures such as a mastectomy or colostomy may make a woman feel unattractive and create body image concerns. A mastectomy will also create a complete loss of sensation in the chest area from a sexual function perspective. Typically the nipple is removed which may impact sexual desire.

Surgery, radiation, chemotherapy, and hormonal therapy can affect a woman's sexual enjoyment.

Also, other medications that are used to treat anxiety, pain or depression may interfere with sexual function.

Cancer Treatments That May Cause Sexual Difficulties

Treatment	Sexual Difficulty
Chemotherapy	May damage the ovaries causing menopause or hormonal changes. Vaginal dryness, decreased desire, and possibly diminished arousal and orgasm.
Hormone therapy	Vaginal dryness.
Radiation to the vagina, cervix, or uterus	Painful intercourse and loss of sensation in the genital area which may make arousal difficult. Some women complain of difficulty achieving an orgasm or orgasms are less intense.
Surgery- ovarian, uterine, vaginal, vulvar	Body image difficulties, vaginal dryness, loss of sensation in the genital area which may make arousal difficult. Some women complain of difficulty achieving an orgasm or they are less intense.
Surgery-Mastectomy	Body image difficulties and loss of sexual or erotic sensation in the breast area.
Medications	Medications given for pain, depression and anxiety may decrease desire for sex or interfere with arousal or having an orgasm.

Solutions for sexual difficulties

There is wonderful news because there are treatment options available. So do not hesitate discussing with your healthcare team your concerns. It is possible for you and your partner to have an intimate relationship.

Therapy

For the woman who can no longer have sexual intercourse you may grieve deeply for this loss. A psychologist, counselor or sex therapist can help you and your partner through this loss and perhaps help you find other ways to become intimate and regain the closeness and pleasure of one another. A trained professional with expertise in this area should provide this therapy. For sex therapy, you may want to find an AASECT certified therapist at www.AASECT.org. It is important for you and your partner to keep communication open if changes in your sexual function are causing you distress.

Loss of desire

Ask your doctor if any of the medications that you are on may be causing decreased desire. This includes chemotherapy, hormone therapies, and antidepressants.

Pain can cause loss of desire. This may be due to dryness and over the counter lubricants or vaginal estrogens could help. Also a pelvic floor physical therapist consult should be considered.

Lack of energy can cause a decreased interest in sex. Talk to your partner about having sex when your energy level is up, perhaps in the morning.

Ask you physician to check if your testosterone is low. Women need some testosterone for good sexual function. However, if you had breast cancer, using replacement testosterone may not be appropriate.

If all physical causes for low desire have been eliminated, then ask to see a counselor. Your loss of desire may be related to depression, anxiety or body image concerns.

(continued on page 10)

Decreased arousal

A decreased ability to become aroused may be due to medications or how one feels about their body. If this has to do with body image concerns, a consult with a mental health provider could be helpful. If it is due to medications, ask your doctor if she/he could switch your medication to one that does not have this side effect.

Vaginal Dryness, Tightness, and Pain

See a gynecologist who has expertise in pelvic and vaginal pain. Talk to this provider about lubricants and vaginal estrogens. You may want to ask for a referral to a physical therapist with expertise in pelvic floor problems. Also, if you have had gynecological surgery and radiation therapy, a pelvic floor physical therapist with expertise in rehabilitation post pelvic surgery and radiation should be considered.

Difficulty reaching orgasm

Medications may cause this, so ask your doctor if the medications you are on or have been on could be causing this difficulty. Antidepressants or anti-anxiety medications can make reaching orgasm more difficult. Some women complain that chemotherapy impacted their ability to have an orgasm. Other women will express that after having their uterus removed their orgasms are less intense.

Conclusion

What is most important is that you continue to seek help. If your doctor cannot assist you, then do not hesitate to ask for a referral or speak with other women in cancer support groups who may know of a doctor or therapist who has helped them.

Announcements

Invitation to Attend TWSHF 4th Education Event

The Women's Sexual Health Foundation and Columbia University College of Physicians and Surgeons Department of Obstetrics and Gynecology invite all women to attend:

Reclaiming Healthy Intimacy, Passion and Pleasure
Saturday, April 4, 2009
New York City at the Club 100
101 Park Avenue

Registration for this event is required and includes a continental breakfast.

The focus will be empowering women on how to address their sexual health concerns and to reclaim the intimacy that they deserve. This is an opportunity to discover solutions from the experts, to ask questions, and to understand why menopause, pregnancy, cancer, incontinence, diabetes, stress and other life changing events can impact healthy intimacy.

For more information on attending this event contact Christine Rein at or **201-346-7014** at cmr2146@columbia.edu.

Becoming A Donor

Supporting the Foundation

Thank you for your interest in supporting the work of The Women's Sexual Health Foundation, an international non-profit organization. We seek to empower women with information about sexual health. It is only through your generous donation that the Foundation can achieve its mission: to provide educational resources with the latest research for women and healthcare providers, to support a multidisciplinary approach to sexual health issues, and to increase worldwide awareness on women's sexual health.

No contribution is too small to further the mission of the Foundation.

All gifts are recognized on the TWSHF website at our Donor page, unless the donor prefers to remain anonymous.

If you would like to make a donation, please send your tax deductible contribution to:

TWSHF
PO Box 40603
Cincinnati, Ohio 45240-0603

Calendar for 2008

February 21 - 24 International Society for the Study of Women's Sexual Health (Annual Meeting), San Diego, California

March 13 - 15 Society for Sex Therapy and Research, Chicago, Illinois

May 3 - 7 American College of Obstetricians and Gynecologists Annual Clinical Meeting, New Orleans, Louisiana

June 15-18 The Endocrine Society Annual Meeting, San Francisco, California

June 25-29 American Association of Sex Educators, Counselors and Therapists (Annual Meeting), New Orleans, Louisiana

September 24-27 North American Menopause Society Annual Meeting, Orlando, Florida

November 8-12 Annual Meeting of the ASRM, San Francisco, California

Donations

As a nonprofit organization, The Women's Sexual Health Foundation is supported through individual donations, memberships, and in a small measure, by the bulk sales of TWSHF brochures and the Journal. We are currently seeking to finance research projects through grants from government agencies and nonfederal sources such as corporations, women's groups, and medical organizations. However, private gifts will always be the mainstay of the Foundation.

All donations are tax deductible. The Women's Sexual Health Foundation will send you an acknowledgement receipt for your tax records.

If you would like to make a donation, please send your contribution to:

TWSHF
PO Box 40603
Cincinnati, Ohio 45240-0603

Information

See www.twshf.org for information on membership, donations, instructions for authors, volunteering, and additional resources.

Editor's Note

The Editor welcomes articles, letters, meeting notices, pertinent internet websites, breaking news, information on support groups, and publications that may be of interest to the readers.

Disclaimer

TWSHF recommends that you consult with your health care provider to determine appropriate treatment. TWSHF is not responsible for any consequences that occur based on information contained in this publication.