

7 Sexuality and stoma care

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The aim of this chapter is to educate nurses on the effects stoma surgery may have on a person's sexuality.

DEFINITION OF SEXUALITY

Human sexuality is a complex issue and plays an important and integral part in our personalities, woven into the physical, social, psychological, cultural and spiritual aspects of our lives, and having an influence on every individual. Sexuality or sexual health has been defined by the World Health Organisation (1975) as 'the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love'. Sexuality is more than the act of sex; it is concerned with relationships and feelings about oneself and others. These in turn have an effect on self-esteem and self-worth. Sexual activity like any other lifestyle activity is variable; knowledge of the degree and desire for sexual activity is an important indicator for consideration when undertaking the initial nursing assessment.

Major changes in sexual role and function are experienced by patients who have undergone stoma surgery, in spite of the sphincter saving surgical techniques and moves towards continent procedures. Although many patients are effectively treated, sexual functioning morbidity remains a probable area of life disruption. Patients with a stoma have not only lost

the means of normal elimination but, in addition, are left with abdominal scars and a protruding appendage on their abdomen. These threats, which can have a devastating effect on the mind as well as the body, varying with intensity and duration, are now recognised in nursing as quality of life issues.

For nurses to understand and recognise any changes in an individual's sexual role and function it is necessary to be familiar with the anatomy and physiology of the male and female reproductive organs, and have an awareness of those body parts which are potential sources of sexual pleasure.

FEMALE ANATOMY

External genitalia is the collective name for the vulva and includes the outer lips (labia majora), inner lips (labia minora), clitoris and vaginal orifice. These lie within the pelvic region. The urethra and anus are associated structures.

The introitus, or vaginal orifice, forms the entrance to the vagina and lies between the urethral opening and the anus. Inside the vagina and partly covering the opening lies a fine membrane known as the hymen.

The clitoris, which corresponds to the penis in the male as a source of sexual sensations, is about the size of a pea, and consists of elongated structures of erectile tissue attached to the pelvic bone. It lies at the top of the vulva, above the urethra opening, covered by a hood-like structure, which forms part of the labia. The glans clitoris, which is covered with a cap of skin, is made up of highly sensitive, vascular tissue.

The labia majora are two large folds of skin, filled with fibrous tissue and fat. Lying between the labia majora are two further thin folds of skin which are the labia minora. Together they form a boundary to the vulva, offering protection to the genitalia. Anteriorly they divide around the clitoris to form the prepuce and frenulum; posteriorly, the two are fused together to form the fourchette. The urethral and vaginal orifices are situated in the vestibule, which is the space adjacent to the labia minora.

Internal genitalia is the collective name given to the vagina, cervix, uterus, ovaries and Fallopian tubes.

The vagina is a hollow fibromuscular tube attaching the vulva to the uterus. It is this space which receives the penis in copulation. Lined with mucus membrane it is mainly without nerve endings and does not contain

any glands. There is a proposed region in the front wall of the vagina, the Grafenberg spot or G spot which is thought to have a high degree of erotic sensitivity. During sexual arousal, secretions that do occur are from the greater vestibular or cervical glands situated near the vaginal orifice. The vagina maintains a pH between 4.9 and 3.5 to minimise infection being introduced from the perineum, the hairless area of skin between the vagina and anus.

The uterus, a pear shaped hollow muscular organ, is situated in the pelvic cavity lying between the bladder and rectum. The flattened body of the uterus is situated over the bladder, with the neck of uterus connecting to the cervix, which protrudes through the anterior wall of the vagina, opening into the external Os. Anatomically the uterus consists of three layers: the outer wall – the perimetrium; a middle or muscular layer – the myometrium and an inner layer or lining – the endometrium. Oestrogen and progesterone hormones secreted by the endocrine system are responsible for changes which occur in the endometrium during the menstrual cycle.

The two ovaries situated on either side of the uterus in the lower abdomen are the female sex glands that store ova and, in the menstrual cycle, produce hormones. Ova are conveyed by peristalsis down the Fallopian tubes, which are situated on either side of the ovary, into the uterus.

The female genital area receives its arterial blood supply from branches of the internal pudendal arteries, which branch from the external pudendal arteries maintained from the external iliac arteries. A network formed from branches of the uterine and vaginal arteries service the vagina. A large venous network connects into the internal iliac vein providing venous drainage to the area. Superficial and deep vaginal glands are responsible for lymph drainage from the vulva and vagina. The autonomic nervous system supplies the uterus and vagina, whereas the genitalia are supplied via the pudendal nerve (Gregory, 1997).

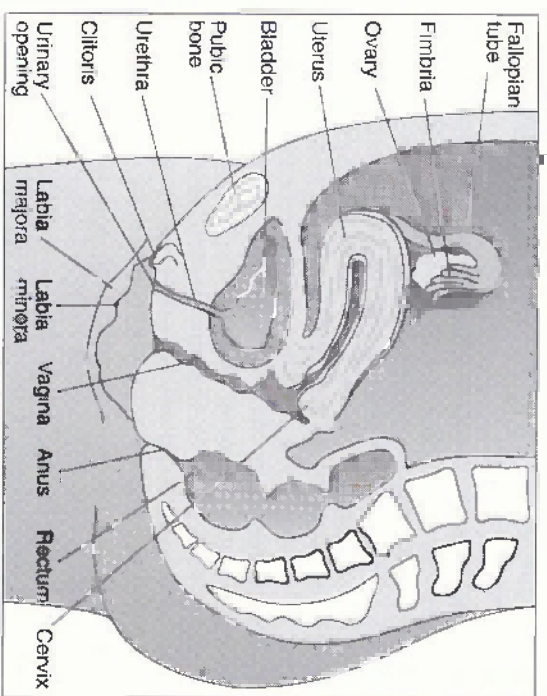


Fig 7.1 Female reproductive system

MALE ANATOMY

The external male genital organs are more visible and consist of the penis and scrotum, which contain further sub-structures.

Formation of the penis is primarily by three parallel cylinders, root and body is by the corpora cavernosa, a pair of cylinders made from tough fibrous tissue, and the tunica albuginea, filled with erectile tissue, which fills with blood during erection. The mechanism for erection is dependent on the structure of this tissue (Bancroft, 1989). The corpora cavernosa extend laterally into the body of the penis where they are attached to the pelvic bone. The corpus spongiosum lies along the underside of the penis between the corpora cavernosa, and contains the urethra, expanding at the distal end into a triangular tip, to form the glans penis. In uncircumcised males the prepuce or foreskin covers this. Blood supply is via branches of the internal pudendal arteries that feed into the deep, dorsal and bulbular arteries of the penis. Networks of veins drain blood into the internal iliac and pudendal veins. The autonomic and somatic nerves supply the penis.

Stimulation of the penis by the parasympathetic nerves will lead to blood engorgement and erection.

The scrotum is a superficial pouch of skin and muscles divided into two compartments, each containing a testis or male sex organ, which are responsible for the secretion of spermatozoa. During foetal development the testes descend from the abdominal cavity into the scrotum. This cooler environment is essential for normal spermatogenesis. Testes are suspended in the scrotum by the spermatic cord. Contained also in the scrotum is the epididymis, a convoluted tube some seven metres long. Maturity of spermatozoa occurs within the epididymis, whereby spermatozoa are either stored or reabsorbed. The epididymis leaves the testes to form the vas deferens. Contained within the vas deferens are the spermatic cord, testicular artery, testicular venous plexus and lymph vessels that maintain the testes via the spermatic cord.

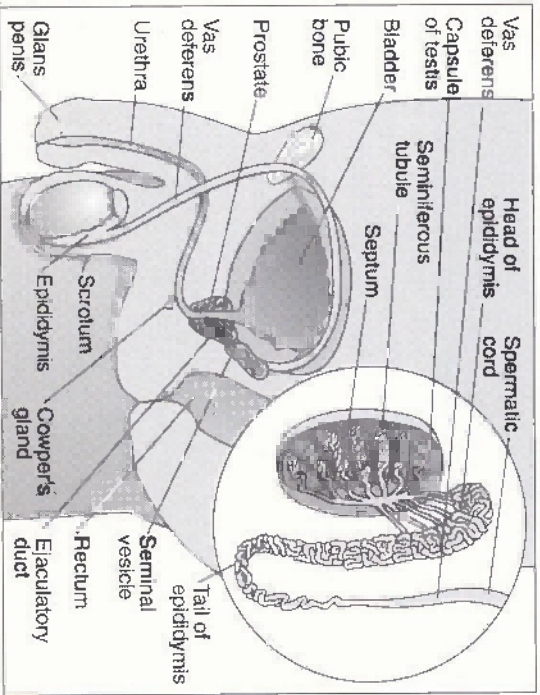


Fig 7.2 Male reproductive system

orgasm and the ability to regain an erection may be a few minutes in a healthy young male; for an elderly person it may be several hours or days.

Male arousal

Masters et al (1995) propose a four stage model which currently appears acceptable and, although physiological responses are not so separable, does assist with the identification and diagnosis of erectile problems. The four stages are:

- ▶ excitement
- ▶ plateau
- ▶ orgasm
- ▶ resolution

Currently there are still some misunderstandings on the precise mechanism of how penile erection occurs. It is known that with stimulation the arteries within the corpora cavernosa become relaxed allowing an increase in the flow of blood into the cavernosal spaces. Erection occurs when the penis becomes engorged with blood. Contraction of the muscles surrounding the penis provides further rigidity. To achieve and maintain an erection demands an intact autonomic nervous system as four coordinating processes are involved: erection, emission, ejaculation and detumescence.

Penile erection may also result from a psychological stimulus (psycho-genic erection) such as erotic fantasies or visual images. This occurs via the sympathetic and parasympathetic nerves. Tactile stimulation triggers a reflexogenic response initiated by the nerves which lie in the fatty tissue within the side wall of the rectum, known as the hypogastric plexus. Emission, which is the first stage of erection, is controlled primarily by the parasympathetic nervous system. Ejaculation occurs when the seminal fluid is propelled along the urethra and expelled from the body. This is activated when closure of the bladder neck and stimulation of the parasympathetic nerve cause rhythmic contraction of the striated ischio-cavernosa and bulbocavernosa muscles.

A build up of body tension, which is subsequently released, followed by a feeling of intense pleasure, can usually be referred to as orgasm. Orgasm may, however, be experienced without ejaculation or erection; it should also be noted that ejaculation could occur without the penis becoming

erect. Following orgasm, ejaculation is imminent, usually within 1-3 minutes.

The phase when the genitalia return to their pre-erectory state is described as detumescence.

Female arousal

Women will undergo similar phases of physiological activity. The excitement or desire phase is indicated by vascular engorgement and swelling of the genital area, in particular the labia, in direct response to stimulation. At the same time there are muscular contractions and vasocongestion of the skin and genitalia, which can increase sensitivity to other parts of the body, including the breasts. Vaginal lubrication occurs in response to this process. The amount of vaginal lubrication is not an indicator of the level in which a woman is aroused and cannot determine that the woman is ready for male penetration of the penis. Lubrication does, however, enable the penis to be inserted more easily and without discomfort. This is then succeeded by the plateau phase where a levelling of sexual tensions will occur necessary to trigger off orgasm, a total body response with the tensions accumulated being discharged. Resolution or final phase occurs in response to this maximum level of excitement with the body returning to its former unaroused state.

EFFECTS OF MUTILATING SURGERY ON BODY IMAGE AND SEXUALITY

Patients undergoing stoma formation face permanent changes to their accepted body image. Lifestyle and sexuality. Sexuality is integrally linked to the concepts of body image, self-concept, self-esteem and self-worth. Changes in physical appearance may make an individual feel less attractive. These feelings can give rise to insecurity, lack of confidence and being 'out of control'; these, in turn, can be a threat to existing relationships and friendships. Stoma surgery therefore has a profound effect on the mind as well as the body. What is seen as a physical problem will transpose into a psychological sequelae, which goes beyond the ability to engage in sexual intercourse.

What is body image?

According to Nevell (1991) the concept of body image is poorly defined but does involve aspects of neurology, sociology and psychology. Several factors can affect body image and, as noted by Price (1986), include genetics, socialisation, culture, race, fashion, the media and health education. Body image can be conceptualised as a 'mental picture of one's own body, an interpersonal experience', or 'the way in which the body appears to self'; in other words what we carry in our mind (Wood, 1975). How we see and feel about ourselves – self-concept – will affect the way an individual accepts any changes to their normal body image. Schain (1980) argues that self-concept consists of four components, namely:

- ▶ The *body self*, which includes physical function and body image.
- ▶ The *interpersonal self* concerned with sexual and psychosocial interaction.
- ▶ The *achievement self* which considers individual status and function; such as the nature and source of employment and role in life.
- ▶ The *identification self* which relates to personal, ethical and spiritual beliefs.

These four areas will have an influence on a person's acceptance of body image. Every individual is unique in the way in which they see themselves, how others relate to them and how they communicate with each other. The appearance of other people can therefore influence how an individual feels and sees him or herself, and affect their perception of others. This infers that if a 'normal' person has problems with their body image, a person whose body image undergoes a change is more at risk (Salter, 1991). McCrea (1984) questioned these facts by suggesting that people with body image problems should not have to undergo such mental anxiety and asked whether it is disease or society that causes the problems.

Concepts of body image and society norms, such as pretty and ugly, normal and different, are developed during early childhood. Throughout these formative years the attitudes of society, parents and peers will influence the way in which an adolescent regards him or herself. For example, stress may be placed on physical abilities, which will be a problem if a disability occurs in later life. Most people are self critical about their body image to some degree and, in the extreme, this can give

rise to feelings of insecurity. Successful survival is dependent on the need to feel confident and be in control of their lives.

Gastrointestinal or urological illness, surgery and formation of a stoma represent a major transition in patient's lives, each stage having the potential for primary and secondary psychological problems. Wade (1990) infers that patients facing stoma surgery also face the future with a change in bodily appearance and loss of elimination control. Research to compare the psychological effects of people with continent stoma suggests that many of the body image problems related to conventional stoma have been erased, and no evidence of major problems with sexual function have been recorded (Salter, 1996).

In life it is not only necessary to adapt to changing patterns of normal body image but also to an altered body image (Price, 1990). The literature therefore suggests that there is more to an altered body image than physical effects which cannot be detached from psychological, sexual and social implications. Anxiety and depression can compound these and any other previously existing problems.

EFFECTS OF SURGERY AND/OR ADJUVANT THERAPY ON MALE SEXUAL FUNCTION

Impairment of sexual function may occur after any major stress, but this should improve in time. If there is a risk of sexual dysfunction it is the responsibility of the surgeon to discuss this with patient and partner before surgery. This allows time for the couple to discuss the possible major impact on their future lives. Ideally specialist sexual counselling should be available and the opportunity for sperm banking should be offered, supported by clear verbal and written information on access and disposal. Sexual function may be impaired prior to diagnosis, surgery or treatment; vague discomfort, pain and general malaise can contribute to a decrease in sexual desire and love making. Patients should be informed that following major surgery, with or without additional treatment, they can initially expect to experience similar feelings resulting in a potential loss of libido and sexual desire.

Erectile dysfunction (the inability to have or sustain an erection) in males may be temporary or permanent, depending on why stoma surgery is being performed. Surgery for ulcerative colitis with formation of ileostomy should not alter sexual function, whereas surgery for pelvic or

bladder cancer is more extensive with possible damage to the prostatic nerve plexus; the parasympathetic and sympathetic nerves, which lie in close proximity to the bladder and rectum, are critical for erection. The autonomic nerves; which control the blood supply to the penis, can be damaged in pelvic surgery, resulting in sensory loss, a further contributor to erectile failure. Research by Joels (1989) states that sexual dysfunction occurs in 43% of male colostomy patients and virtually all following radical cystectomy for cancer.

Vascular insufficiency following radiotherapy treatment for pelvic cancer can contribute to the cause of erectile failure. Other factors to consider are the pre-existing pathology, such as diabetes, and medications that may block testosterone action, such as cimetidine for the treatment of gastric/duodenal ulcers (Leiblum and Rosen, 1992).

Total pelvic exenteration, which involves removal of all organs in the pelvic cavity, including the rectum, bladder and all male reproductive organs, results in loss of male genitalia and double stoma. Some men may not actually ejaculate whereas others experience retrograde ejaculation (dry orgasm) where the semen is ejaculated backwards into the bladder. When passing urine the colour will be changed to a 'white, milky appearance'. Men in this situation feel the intensity of orgasm but say that the experience is different.

Radiotherapy to the pelvic area can result in reduced libido, less wetness, orgasmic difficulties and infertility. Some forms of chemotherapy will have similar effects. Both will increase symptoms of lethargy, weakness and body image changes.

The psychological effects of stoma surgery can be an even greater contributor to male sexual dysfunction than the physiological and pharmacological causes. We have discussed some of the physical sequelae, which may only be apparent to the patient and their sexual partner. Chemotherapy can lead to hair loss or hormonal treatment, resulting in the development of female characteristics, such as voice changes or increased breast development. These can enhance existing effects and leave a man feeling stigmatised and distressed by fear of rejection by peers and 'the partners. Culturally men are seen to be macho, strong and 'the breadwinner', and may feel unable to talk about their true feelings, fearful that this will be interpreted as a sign of weakness or not coping with the disease or treatment.

Table 7.1 Significant contributory factors to male sexual dysfunction

1. Loss or potential loss of sexual function is seen as a loss of manhood and the threat of not fulfilling his gender role. Men often use emotional withdrawal as a coping strategy for emotional distress.
2. Anxiety to perform and fear of rejection is a major cause of erectile failure, resulting in relationship tension and withdrawal from intimacy.
3. Depression and mood disturbance in the more debilitated patients is another cause of erectile failure.

EFFECTS OF SURGERY AND/OR ADJUVANT THERAPY ON FEMALE SEXUAL FUNCTION

The condition necessitating surgery and the type and technique of stoma surgery performed can both affect the degree of sexual/psychological problems encountered and have implications for nursing practice. A woman who has had an ileostomy for long-standing ulcerative colitis, where the chronic symptoms will have had significant impact on lifestyle activities, will probably approach surgery more positively than a woman recently diagnosed with rectal cancer requiring a colostomy. Many nurses recognise that patients are facing a life crisis but as Copey et al (1992) found in their study of gynaecological patients, nearly one-third of the women would have liked more information on the operation's effects on sexual function and indicated preference of partner involvement. Medical and health professionals generally see the effects of surgery, medication or adjuvant cancer therapy on female sexual functions as a low priority. Borwell (1996) in her study on specialist stoma care nurses found that if the issue of sexuality was raised prior to surgery, impairment to male sexual function would be acknowledged.

Women with rectal cancer who undergo abdominal perineal excision of rectum with permanent colostomy can possibly experience shortening and narrowing of the vagina. It is not surprising that when intercourse is resumed after surgery, a degree of dyspareunia (painful intercourse) will be experienced. An unhealed perineal wound or discomfort around the perineum may inhibit coitus (penetrative sex). Another possible result of this type of surgery is loss of genital sensation due to peripheral nerve damage and vaginal dryness. Dyspareunia can also occur due to anatomical changes, such as damage to the posterior vaginal wall or

shortening of the vaginal vault, or decrease in the volume of vaginal secretions. Total pelvic exenteration, involving the removal of uterus, Fallopian tubes, ovaries, bladder, rectum and vagina, is considered at cancer diagnosis or recurrence when the disease is thought to be resectable and will have a profound and severe effect on function. The formation of a urinary and faecal stoma has further body image, self-esteem and sexual implications. Additional considerations are the rationale for undertaking this drastic form of surgery and the attraction of a final attempt to cure. Initially sexuality may not be perceived as a problem, with thoughts and energies being focused on survival. Research conducted by Anderson and Hacker (1983) identified a reduction in the frequency of sexual activity, low sexual arousal and satisfaction, and disruption of body image and confidence. Following total pelvic clearance women are unable to resume sexual activity if they have not undergone vaginal reconstruction.

Radiotherapy to the pelvic/vaginal area will have an effect on vaginal secretions, thinning of the vaginal lining and loss of vaginal elasticity. There is also an increased risk of vaginal fibrosis and stenosis (narrowing of the vaginal introit), resulting in dyspareunia and orgasmic difficulties. Depending on a woman's menstrual status, infertility could also be a future problem.

Chemotherapy may cause similar problems depending on the types of drugs used. General malaise, lethargy and weight loss are a realistic expectation following major surgery and, as previously stated, should be included in the pre-treatment phase information package. Surgical intervention with or without adjuvant therapy will enhance body image problems and can be a constant reminder of the underlying disease.

Nursing assessment and advice on the management of vaginal dryness should consider the pre-disposing factors to which the condition relates, for example a woman with gynaecological cancer would not usually be treated with an oestrogen based cream. There are several commercially produced water-soluble lubricants, reducing discomfort to encourage lovemaking. A disadvantage could be the anticipation that coitus will take place. An alternative spontaneous recommendation would be the use of saliva, always readily available, which can enhance lovemaking if offered by the partner. Regular use of a vaginal dilator with a water-soluble lubricant can also help to prevent vaginal stenosis. Identifying problems concerned with fear, discomfort or pain while making love will enable the nurse to discuss adopting different positions to enhance comfort. The

superior position allows the woman to have greater control over the timing and degree of penetration.

Following a debilitating illness another contributor to pain and discomfort is often caused by undetected conditions such as monilia vulvovaginitis, a fungal infection (thrush). Monilia are commonly found in the vagina but may proliferate if treatment for another condition involves the use of some antibiotics, which can disturb the normal mucosal flora. Symptoms experienced are intense burning and itching of the vulval area; a thick curd-like discharge may also be present. An antifungal/acid topical preparation is an effective remedy for this condition with an emphasis on personal hygiene. A typical incident recently occurred involving a seventy-year-old woman who had undergone panproctocolectomy for long-standing ulcerative colitis. While promoting and discussing aspects of care, comments were made relating to discomfort and irritation around the perineum. Examination revealed an extensive monilia infection, and yet both nurses and medical staff had reviewed the area for wound healing without comment, in spite of the patient's reference to soreness around her genitalia.

Homosexual patients

The homosexual patient with a stoma does have the same needs for information about ostomy surgery and its implications. There can be problems about disclosure of sexual orientation and sensitive concerns, making it more difficult for them to receive help. It is important to distinguish the nature of the homosexual relationship and who is the recipient in the relationship. In the patient who has had the rectum removed and is the reciprocal partner, the couple should be warned about the dangers of having penetrative sex via the stoma. Anal intercourse for some homosexuals is a source of great pleasure and possible sexual identity (Savage, 1987) but this is no longer possible following perineal excision of rectum.

INFLUENCES OF SURGERY ON BODY IMAGE AND SEXUALITY

Factors affecting both genders, whatever their sexual orientation, often relate to a feeling and fear of rejection of the stoma by their partner. Discussion of positive attributes and on how to restore confidence will

help to increase self-esteem and the belief that there is life after stoma surgery. At the same time the changes which have occurred as a result of surgery or disease need to be acknowledged. Practical suggestions could include ways to enhance personal presentation and attractiveness to a partner, which will raise an individual's confidence and self-esteem. For a woman suggestions on how to achieve this could include wearing pretty lingerie, using a pouch cover or an opaque pouch to disguise the contents or introduction to a smaller style of pouch. Other tips should focus on pouch security, ensuring the pouch is emptied prior to love making, thus reducing distress and embarrassment from leakage.

Psychological factors may also predispose to a reduction or cessation in sexual activity affected by the changes to body image, diagnosis, or non-acceptance of the stoma itself. Adjustment following ostomy surgery has been investigated widely; the documented areas of concern are those that relate to sexual attractiveness. Fears have been expressed about odour, noise and appliance leakage during sexual activity (Druss et al, 1968). Other concerns relate to the reaction of a partner; fertility and childbearing (Dyk and Sutherland, 1956; Gruner et al, 1977).

Expressing sexuality is much more than intercourse alone – it is a source of human contact, comfort, and security, a measure of self-worth, providing cohesion within a relationship. The nursing diagnosis acknowledges altered body image in the care plans of patients who will experience disfigurement due either to surgery or subsequent treatments, such as radiotherapy, chemotherapy or the disease process itself. This assumes that every nurse will know what constitutes a change in body image and how it is related to health. Based on these assumptions it also implies that nurses should have understanding and are equipped with the appropriate skills to offer some form of counselling (Mellor, 1996). Research on the nursing and medical profession in this area, however, would argue to the contrary that open discussion about sexuality and other areas seen to be of a sensitive nature remains uncommon. It is thought that as many as 84% of surgeons fail to invite open discussion about potential sexual difficulties before surgery (Rubin and Devlin, 1987). These issues are rarely raised by nurses, family doctors or junior hospital doctors, so patients often discover their physical malfunction postoperatively and suffer additional psychological trauma. This reluctance by health professionals to discuss sexual issues is further recognised by Webb (1985a) and Borwell (1996), and as Woods (1975) infers, 'loss of control of a bodily function such as that experienced by

ostomates generates anxiety about adult sex role identification and social interaction'.

The bereavement process is a common analogy used to describe the feelings and emotions that these patients and their families will undergo (Kubler-Ross, 1970; Bowlby, 1980; Buckman, 1992). Gloeckner (1984) identified that over half of the respondents to his research noted a decrease in feelings of sexual attractiveness and unacceptability in the first year after surgery. The implications for nurses and health professionals in the management of ostomy patients are therefore evident.

REHABILITATION AND THERAPEUTIC HELPING IN NURSING

Ill health is associated with impaired sexuality. However it is also apparent that a decline in sexual health is not dependent on poor health. Equally, good health does not depend on sexuality as often supposed – many people are sexually inactive and will vary according to individual, personal characteristics.

Stoma patients have the potential to experience clinically significant psychological problems following surgery, which frequently are not recognised by health professionals, such as surgeons and stoma care nurses. Preoperative preparation and continuity of care following discharge, particularly for those with an increased risk of psychiatric morbidity, is critical if these current statistics are to be improved (White and Hunt, 1997; Wade, 1989). Psychological disturbance to sexual function is mainly rooted in feelings of guilt, fear, anger, anxiety and depression. Lack of knowledge, embarrassment and ineffective communication by the nurse can contribute to these difficulties.

Any anxieties that the patient, their partner or children may have will need to be explored. These could be related to their feelings about lifestyle activities, employment, personal relationships and possible changes that the future may bring. Some couples do have difficulty in communicating with each other about sexual anxieties. Many patients admit being aware of stigma to a degree (Devlin et al, 1971; Macdonald, 1982); they no longer see themselves as 'normal', resulting in withdrawal from social contact.

Rehabilitation requires the nurse to have knowledge of or access to current information about when to resume sexual activity, and resources and aids available for male and female sexual dysfunction.

Following major pelvic surgery it is usually agreed that sexual activity can safely be resumed once healing of the perineum has occurred. This is usually determined at the post-discharge follow-up clinic, approximately six weeks postoperatively. Physical weakness is commonly experienced by patients in this phase; being sexually active is not always seen as a priority. Performance anxiety and fear of failure between a couple can be associated with sexual difficulties and not physical impairment. Information should also reinforce the need for a realistic time span for nerves and other structures to recover before any permanent estimation of dysfunction can be determined. Preoperative assessment should have identified any existing sexual problems relating to pharmacology or other conditions that can be dealt with in an appropriate manner.

In the male with erectile dysfunction, intracavernosal injection therapy and vacuum and constriction devices have been available for some time with varying degrees of success. Couples who are motivated, prepared to practise and receptive to changes in their sexual activity to include the device are most likely to achieve success. Penile prostheses can be a positive means of providing an erection following disease or injury, offering a more natural solution to erectile dysfunction, but they do have their limitations. Pharmacology and the new oral agents are the current shift for the treatment of erectile disorders. Sildenafil (Viagra) has received a controversial reception in the United Kingdom, largely due to the financial implications and lack of guidance on its administration. Sildenafil is effective in treating erectile dysfunction of broad aetiology but does require a thorough patient assessment prior to usage.

Successful pregnancies are possible depending on the type of surgical technique. Contraception and preconceptual advice should be addressed when assessing premenopausal women. Intrauterine devices are not usually recommended, oral contraception being preferable, although absorption may be affected. This can be determined by the type of operation or the particular contraceptive pill prescribed.

There is minimal evidence regarding the pharmacological advantages in the treatment of female sexual dysfunction. Sildenafil and other oral agents have been proposed as beneficial agents due to their enhancing effect on vasocongestion of the vagina and clitoris.

LEARNING TO ASK

Nurses generally will inform their (male) patients of the potential physical effects of ostomy surgery on sexual function, irrespective of the fact that this problem may already have been in existence for some time. Assessment can legitimise the patient's sexual concerns, and clarify and reinforce diagnosis, terminology, prognosis and proposed treatment, including any side effects.

The following considerations are relevant for the stoma patient:

- ▶ past and current physical status;
- ▶ patient's psychosocial and sexual status;
- ▶ their current psychological status;
- ▶ their current social status.

Within these factors are the attitude of the partner toward the stoma and their emotional and physical health which are all intertwined (Coates, 1989). Lomont et al (1978) also acknowledged the importance of an educated and informed partner in total sexual rehabilitation. Where appropriate it is important to include the partner in teaching sessions. Commonly, focus is on a patient's sexuality and the potential effects of the partner are frequently overlooked. The 'well' partner can also suffer from fatigue, be hesitant to initiate a relationship for fear of causing pain or damage to the 'ill' partner and may feel guilty. Within sexual counselling (or helping) in nursing the main objective is to provide an insight into an individual's pattern of communication and interaction. As patients progress through the rehabilitation period, non-intrusive questioning in follow-up can establish how well they are reintegrating back into their previous lifestyle. Observation on a person's appearance, voice and mood can help nurses assess how well they are managing. Assessing the extent of their sexual difficulty can sometimes be a problem as there can be a reluctance to talk about intimate problems, hence the importance of a sexual health assessment as part of the overall care. A nurse who feels comfortable while listening, and who encourages and shares her knowledge, can help to clarify sexual problems, consider solutions or maybe compromise and give permission for the patient to consider changes in established patterns of sexual expression.

Adaptation of a recognised framework such as the PLISSIT model (Annon, 1974) can offer an assessment tool to be used with patients and will also

the freedom to express their sexual concerns and difficulties. At the end of this intervention patients should be able to recognise their sexual behaviour as an expression of the dynamics of a relationship and, where appropriate, be offered an opportunity to communicate this to their partner. Giving limited information is an important part of the sexual counselling process and can contribute to the insights and patterns of communication and interaction.

Specific Suggestions (in the action stage)

Some patients will need more than permission and information. For example, the patient who has disclosed his homosexuality and has undergone excision of rectum with a permanent colostomy will possibly need assistance with understanding new practices of sexual behaviour. This should take the form of involving the other partner in a relationship to help with negotiated tasks designed to enhance communication between the couple. A necessary requisite for the resolution of sexual problems is the creation of a humanised sexual system (Kaplan, 1974). The essential ingredients are open communication and the expression of feelings that portray a genuine willingness between the couple for connecting and resolving such problems. Developing these abilities will help patients respond more effectively to their sexual concerns.

Intensive Therapy (a behavioural based action stage)

Nearly every patient will benefit from counselling with a sexual focus, through which permission is given and the information acquired is used to enhance further understanding and gain deeper insights into the patient's particular sexual problems. There is a group of patients who will require specific systematic behavioural programmes designed to change sexual behaviour and function. This group needs the skills of a recognised sex therapist that can offer intensive therapy tailored to their individual needs. Nurses and other health professionals who have identified and acknowledged this need with their patients are responsible for ensuring a smooth transition to an appropriately qualified therapist. (Adaptation of RELATE handout, 1993, Annon, 1974)

provide a way in which nurses can identify their own strengths and weaknesses to action other more appropriate agencies.

Table 7.2 PLISSIT Framework

P. -	Permission (giving)	EXPLORATION
L.I. -	Limited Information	UNDERSTANDING
S.S. -	Specific Suggestions	ACTION
I.T. -	Intensive Therapy	

Permission (the beginning, exploratory stage)

Patients with sexual difficulties or issues to be discussed relating to their medical condition may need permission to: acknowledge they need help; discuss sex; feel that they are respected for who they are and can raise issues which concern their sexual behaviour and relationships; have complex feelings.

Permission giving requires the nurse to be:

- ▶ sensitive and use the skills of active listening;
- ▶ introduce and initiate discussion by adopting a direct and explicit approach, using language that the patient understands, modelling her knowledge of sexual language and behaviour.

Offering patients the freedom to talk about their sexual concerns will help them to clarify what the actual and potential problems are and will form the basis of assessment for any future counselling or support.

Limited Information (in the understanding stage)

Information already acquired will enable the nurse to assess what difficulties are being experienced, whether to engage in further discussion or counselling or if patients should be referred for more expert help. Sexual counselling explores the deeper insights, awareness and understanding of the patient's problem. A patient may, for example, disclose that he is homosexual and will want to know how having a colostomy will affect his relationships with other homosexuals. At this stage the nurse will probably need to supply additional, relevant information which could be written details of appropriate associations, such as SPOD (Sexual and Personal problems Of the Disabled). This type of information cannot compensate for the interaction between patient and nurse, but it will support and provide another dimension. Offered with sensitivity this type of information can often liberate patients and provide

SEXUAL HEALTH ASSESSMENT IN COMMUNITY CARE

Assessment should include a description of past patterns of sexual expression, recent changes in activity, knowledge of illness, related changes in sexual function and beliefs about sexual expression. An individual's concern about sexuality will not necessarily be associated with a change in sexual function. It is, however, necessary to determine an individual's and their partner's degree of satisfaction or dissatisfaction in fulfilling their sexual needs.

Many authors suggest a full history should be taken from everyone. Various restraints play an integral part of physical/psychosocial functioning, in particular, time, embarrassment on the part of nurse/patient and lack of general acceptance of sexuality.

- ▶ **Timing is important** in the acceptance by the patient when raising issues that have a sensitive connotation. It has been noted that the optimal time is not on initial interaction with the patient but it could be argued that a sexual history should be taken alongside a nursing/medical history. The following suggestions could form a useful criterion:
 - ▶ **Age** – considerations should include the very young and elderly widows/widowers, as it may be inappropriate within some of these groups. However it is mandatory for those in late adolescence and people in an existing relationship. Individuals not in a current relationship should not be excluded on these factors alone: thinking about future relationships when presenting with an illness or other medical condition can be an added source of anxiety.
 - ▶ **Gender** – there may be differences in how this is approached between men and women when undertaking assessment.
 - ▶ **Context of consultation** will influence who is interviewed, and the reason for and timing of presentation.
 - ▶ **Conservatism** – this can be the greatest barrier on the part of patient/practitioner. Again nurses should exercise the skill of being non-judgemental about their patients.

Where to take a sexual health assessment

Within the clinical setting this can create many barriers, for example lack of privacy, noise, interruptions and the sensitivity of the issue. In community practice there will be other considerations relating to the environment, timing and privacy. Confidentiality should be assured at all times and choosing the appropriate 'moment', that is not when a patient already feels threatened or vulnerable.

Language

Do not invite a negative response by asking questions such as, 'Have you ever...? Patients will also not expect nurses to use 'slang' words. Check out the patients understanding of terminology before you start. 'Sleeping with someone' may mean having penetrative sex or it could mean being close in a relationship and just sleeping in the same bed. When referring to parts of the sexual anatomy, drawings can be a useful way of illustrating anatomical parts. Homosexual behaviour has been commonly thought to mean anal intercourse. Use open questions to elicit a response, for example: 'Is there anything else at all you would like to ask or tell me about? If you should think of anything later, do mention it to me or anyone else you feel can help.'

Once you are in discussion, additional questions can be used for each problem mentioned: 'Could you tell me a little more about that?' 'When did that first happen?' 'How do you think people can help you with...?' (Adapted from Webb, 1985)

Teamwork

The concept of working together in healthcare indicates important messages for planners, managers and practitioners. Interprofessional work raises many issues. Carrier and Kendall (1995) identify a tension in conceptualising multiprofessional work as a cooperative enterprise in which traditional forms and divisions of professional knowledge and authority are retained. A more radical review of interprofessional work implies a willingness to share and give up exclusive claims to specialised knowledge and authority if other professional groups can meet the needs of clients more efficiently. Focusing on the ostomy patient, health policy demonstrates a shift from disease management and an illness service to emphasis on health and its promotion. Each major professional group

Management of sexual problems following stoma surgery has to acknowledge that any physical effects of sexual dysfunction will be psychologically interrelated and are inseparable.

Learning outcomes

- ▶ The impact of stoma surgery and treatment on sexuality.
- ▶ The problems that may arise following stoma surgery on a person's sexuality.
- ▶ Why patients undergoing stoma surgery incur changes in sexual function.
- ▶ Strategies that can have a positive influence on patient care.
- ▶ The nurse's role in promoting a healthy sexuality.

'How well the patient functions sexually after we have finished with him will depend largely on how effective we have been. If sexuality is part of the quality of life, then healthcare professionals can no longer ignore these components of nursing care.' (Wells, 1990)

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proclaims that health promotion lies at the foundation of their work and is an important part of their roles.

CONCLUSION

The aim of the nurse as a therapeutic helper is to improve patient care. According to Corner (1997) the features most common to this development are:

- ▶ Adopts an integrated view of the individual.
- ▶ Offers care that is participative, collaborative and empowering.
- ▶ Undertakes deconstruction of the environment/system of care to enable radical changes in caring to take place.
- ▶ Involves reflection and evaluation of the process of nursing.
- ▶ Focus of care should be need/problem oriented.
- ▶ Aims to move individuals towards healing and health in the broadest sense.

One of the most important improvements in care might be more sensitive and thoughtful attention to the frequency and quality of communication, with the patient.

Once discharged appointments will be made for surveillance by medical staff and the specialist stoma care nurse within a specified time frame. If the patient does not attend, this will be documented and investigated. Many stoma care nurses manage direct access referrals and clinics for patients who have physically related stoma problems or other concerns. There are always many causative factors present; sometimes these can be attached to the current situation, for example long term relationship disharmony. What needs to be defined for a management programme is a thorough exploration of a couple's attitudes and values to identify the root cause of sexual dysfunction. One must also consider other predisposing and precipitating factors such as the patient/partner who does not want to resume sexual functioning.

Example: A woman in her early fifties had an active sex life with her husband and through discussion it was explained that there should be no reason why this would change after surgery. Her comment: 'Please don't tell my husband that. Having this operation can be an excuse not to have sex any more.'

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