A review of the research literature indicates that erectile dysfunction (ED) occurs as a result of treatment for prostate cancer (Bottomley et al., 2007; Carson, Hubbard, & Wallen, 2005; Donatucci & Greenfield, 2006; Henderson, Andreyev, Stephens, & Deamaley, 2006). While this outcome is well documented, knowledge of appropriate nursing interventions is lacking and often not a part of the plan of care. Nurses are responsible to promote quality of life and should address sexual changes in plans of care. Since only a percentage of men recover the ability to have erection firmness and rigidity necessary for intercourse following prostatectomy, there is a gap between research and practice.

The extensive literature addressing ED following prostatectomy is a sign of considerable interest about this issue (Canada, Neese, Sui, & Schover, 2005; Katz, 2006; Ponholzer et al., 2005). Men are being diagnosed at a younger age as a result of early detection and thus have more treatment choices. Sexual functioning and fertility issues are greater concerns to this population, because of their age (Teloken, 2007). As a result of treatment efficacy, prostate cancer patients survive longer, increasing the emphasis of sexual issues as a key variable for quality of life.

State of the Science

Erectile dysfunction has been reported in virtually all men with prostate cancer treatments. External beam radiation therapy results in a gradual decline of erectile functioning (Kendirci, Bejma & Hellstom, 2006; Penson et al., 2000). Prostatectomy causes immediate erectile dysfunction up to 3 months or more postoperatively (Goeman et al., 2006). Complete recovery of erectile potential may require up to 2 years, with a mean of 18 months (Sim et al., 2006). Many patients do not experience full recovery of erectile functioning (Sowery, So, & Gleave 2007).

Although statistics are not reassuring, there are improvements in preserving erectile function after prostatectomy. Erectile recovery rates for those having bilateral nerve-sparing surgery at major academic centers range from 60% to 85%. When performed in community hospitals, the rates are lower, ranging from 30% to 70% (Kessler, Burkhardt & Studer, 2007). However, Madsen and Carney-Code (2006) report non-nerve-sparing surgery results in only 5% recovery of erectile functioning. Results from the CaPSURE study reported 20% recovery of “potency” within a year (Lubeck et al., 2000). The Prostate Cancer Outcomes Study (1,292 participants) reported a 59.9% recovery at 18 months for those with radical prostatectomy for localized prostate cancer (Kendirci et al., 2006).

Psychological Impact

Men about to undergo prostate cancer treatment and spouses/partners may perceive the diagnosis as life threatening. A stressful emotional reaction to the diagnosis can impact sexual functioning prior to treatment. Discussions about treatment options also introduce sexual anxiety, for each treatment decision includes the effect on erection and ejaculation (retrograde ejaculation). For a small group of men, “psychogenic erectile dysfunc-
tion complicates recovery of sexual function” (Schover, 2000, p. 405). Performance fears and changes in body image may inhibit achievement of an erection (Rosen, 2000).

Couples who discuss their concerns about changes in sexual functioning have an opportunity to increase intimacy at a time when both need additional support. If discussion is avoided, the couple may withdraw from each other (the patient, to avoid sexual frustration and sense of failure; and the spouse/partner, to protect the patient). Mutual avoidance inhibits potential sexual pleasure, emotional intimacy, and quality of life.

Ideally, these issues should be addressed preoperatively and postoperatively in a relaxed, encouraging atmosphere. This format will assist the couple to manage the physical and emotional changes and promote continued, although often altered, sexual functioning.

Erectile Physiology

Vascular and neurological mechanisms, triggered by psychological and sexual stimulation, are involved in producing erections. Mental and physical sexual stimulation lead to parasympathetic activity, allowing relaxation of the smooth muscle bundles in the penis. Blood flows into sinusoidal spaces that encompass the corpora cavernosa (two cylinders of spongy tissue within the penis), creating an erection. Blood remains in the corpora cavernosa while the engorged sinusoidal spaces apply pressure on the veins. When the sympathetic nervous system is stimulated, the smooth muscle fibers contract, pressure on the veins is released, and blood flows out of the corpora cavernosa (detumescence) (Katz, 2006).

Prostate surgery damages the neurovascular bundle, which interferes with the neurovascular mechanisms necessary for erection. Even when nerve-sparing approaches are utilized, surgery traumatizes the neurovascular bundle. The loss of nerve connection to the corpora cavernosa starts a process of degeneration and atrophy of the cavernosal tissue (chambers of spongy tissue running the length of the penis and filling with blood to produce an erection). Erectile dysfunction reduces the blood circulation, and thus oxygen, to the penis, increasing fibrosis in the penis following surgery. This has been supported through numerous investigations (Kendirci et al., 2006). Venous leakage (another mechanism in ED) has also been found in prostatectomy patients when not in a “penile pharmacological vasoreactive active program” (Kendirci et al., 2006, pp. 187-188).

Treatments for ED focus on relaxing the smooth muscle to allow blood to enter the corpus cavernosum. Psychological (cognitive-behavioral) interventions aim to relax the individual, allowing parasympathetic activity, and thus achievement of erection. Physiological interventions also aim to increase blood flow into the corpus cavernosum. The phosphodiesterase-5 (PDE5) inhibitors relax smooth muscles to allow blood flow into the penis. Vacuum devices create space in the penile tissue, drawing blood into the corpus cavernosum.

Surgical and Pharmacological Treatment of Prostatectomy-Induced ED

Clinical trials for ED have focused on surgical techniques, PDE5 inhibitors, intracavernosal injections, and vacuum devices to decrease the incidence of ED following prostatectomy (Kendirci et al., 2006). Nerve-sparing surgical techniques promise better functioning for a large number of men, and combined with use of sildenafil or PDE5 inhibitors, or use of intracavernosal injections of trimix and intraurethral suppositories, improve results even more (Kendirci et al., 2006). Development of techniques to repair nerves (sural nerve grafting) for preventing ED is promising research, but not yet conclusive (Kendirci et al., 2006). Investigation of neuroprotective and neurotropic agents is ongoing, but studies are not yet completed (Madsen & Ganey-Code, 2006).

The most important factor in recovering erectile function following radical prostatectomy is preserving the cavernous nerves. Men having bilateral nerve-sparing radical prostatectomy (NSRP) are more likely to return to their previous baseline of sexual functioning than those with unilateral or non-NSRP.

Additional factors involved in predicting a return to presurgical sexual function are (a) presence of comorbidities (“diabetes, hypertension, atherosclerosis, hypercholesterolemia, smoking and cardiovascular disease”) (Kendirci et al., 2006, p. 188), (b) “clinical stage, grade and location of tumor” (Kendirci et al., 2006, p. 188), (c) previous sexual functioning (Kendirci et al., 2006, p. 188) and frequency (Raina et al., 2005), and (d) age (Kendirci et al., 2006, p. 188). Active sexual involvement prior to surgery is a positive factor in recovering erectile ability (Kendirci et al., 2006). Pre-surgical sexual functioning predicts level of erectile recovery. Men under age 65 years have more success in returning to baseline sexual functioning (Kendirci et al., 2006; Raina, Agarwal, & Zippe, 2005) (see Table 1).

Kendirci and colleagues (2006) note that “researchers have demonstrated that nightly use of sildenafil significantly increased the overall quantity and quality of nocturnal erections as recorded by RigiScan...in men with erectile dysfunction when compared with placebo” (p. 189). Furthermore, the administration of 50 to 100 mg of sildenafil nightly for 7 months resulted in “a significant benefit in men after undergoing bilateral NSRP” (p. 189). This treatment regime oxygenates tissues traumatized from surgery, promotes healing, and prevents scar tissue formation. Intracavernous prostanooids (increased with oxygenation) also protects the cavernosal smooth muscle. PDE5 inhibitors are less effective when neural transmission is interrupted from surgery.
Positive Factors

- Bilateral nerve sparing (most effective)
- Surgeon’s skill and amount of experience
- Under 65 years at surgery (fewer erectile difficulties following surgery)
- Early stage and localized tumor
- Active sexual involvement improves outcome
- Firm erections sufficient for intercourse on a regular basis
- Absence of diabetes mellitus, hypertension, smoking, cardiovascular disease or other diseases affecting sexual functioning
- Academic health centers (up to date procedures used regularly)
- Community settings (may not offer nerve-sparing surgeries)

and are also not recommended for patients with certain co-morbidities. Intracavernous injections or use of a vacuum erection device may be recommended for those unable to use PDE5 inhibitors. These interventions increase penile blood flow, oxygenating traumatized tissues. Research results using these approaches have been positive (Kendirci et al., 2006). Penile prostheses may be recommended for those who do not respond to other approaches, or if nerve-sparing surgery is not possible. The overall research opinion is that “pharmacologic penile rehabilitation protocols are beneficial in the recovery of erectile function following radical prostatectomy” (Kendirci et al., 2006, p. 190).

Who Gets Nerve-Sparing Surgery and Pharmacologic Treatment Following Prostatectomy?

Many couples receive no help coping with the sexual changes that occur as a result of prostatectomy, in spite of considerable research supporting ED treatments. Kendirci and colleagues (2006) report that in a study of 1,977 men, about 50% reported receiving ED treatment after undergoing a prostatectomy. Although physician surveys indicate that pharmacological erectile rehabilitation is widely practiced with patients undergoing prostatectomy (Teloken, 2007), patient surveys report a different conclusion (Herkommer, Hiespodziany, Geschwend, & Volkmer, 2006; Kendirci et al., 2006). Health care providers are not always effective in providing information, counseling, and rehabilitation.

The health care setting also affects who receives nerve-sparing surgery. Patients receiving care from physicians in community-based settings and from surgeons who do fewer prostatectomies, are less likely to receive nerve-sparing surgery and also have decreased return of erectile functioning following prostatectomy. Nerve-sparing surgery is not routinely available in many community-based practices (Madsen & Garney-Code, 2006).

Nursing Role

Oncology nursing standards include addressing patients’ sexual concerns. Nursing literature provides guidelines for implementing assessment and interventions, but evidence-based guidelines drawn on clinical trials are not available. The evidence for sexual counseling by nurses is based on expert opinion from other disciplines (psychology, sexual counseling, and therapy), qualitative studies describing sexual concerns and recovery following prostatectomy, and on pharmacologic studies. Principles used for sexual counseling and therapy in other disciplines provide guidelines for nursing (Shell, 2002). Albaugh and Lewis (1999) and Lewis and Albaugh (2000) provide an outline of nursing assessment techniques and interventions which may be used for assessing and assisting these individuals.

Nursing responsibilities include assessment and intervention to improve sexual functioning for patients undergoing prostatectomy or radiotherapy for prostate cancer. Evaluation of outcomes should focus not only on erectile ability, but on development and use of sexual skills other than intercourse and maintenance of intimacy and couple involvement in sexual activity (Darst, 1988).

Introducing Sexual Assessment

Sexual assessment should take place after rapport has been established with the patient (Montuor, Rogers, Coleman, Robinson, & Pickett, 2001). Begin by addressing the two concerns men have following prostate surgery: incontinence and erectile function (Madsen & Garney-Code, 2006). Patients will often cross the social taboo to discuss sexuality when invited by the nurse, but may not ask questions otherwise (Darst, 1988; Maurice, 1999). Management of incontinence, although not the focus of this article, needs discussion as well, as sexual image can be disturbed by this symptom.

Barriers to addressing sexual

### Table 1.

<table>
<thead>
<tr>
<th>Area of Assessment</th>
<th>Positive Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage and location of cancer</td>
<td>Early stage and localized tumor</td>
</tr>
<tr>
<td>Type of surgery</td>
<td>Bilateral nerve sparing (most effective)</td>
</tr>
<tr>
<td>Quality of surgical intervention</td>
<td>Unilateral nerve sparing (next effective)</td>
</tr>
<tr>
<td>Where surgery conducted</td>
<td>Surgeon’s skill and amount of experience</td>
</tr>
<tr>
<td>Sexual activity prior to surgery</td>
<td>Academic health centers (up to date procedures used regularly)</td>
</tr>
<tr>
<td>Co-morbidities</td>
<td>Absence of diabetes mellitus, hypertension, smoking, cardiovascular disease or other diseases affecting sexual functioning</td>
</tr>
<tr>
<td>Age</td>
<td>Under 65 years at surgery (fewer erectile difficulties following surgery)</td>
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</table>
concerns include nurses’ time and reluctance to initiate the conversation. Nurses believe they should address sexual issues, and that patients want to discuss sexuality, but perceive that patients do not expect to be asked about sexuality. This influences nurses to omit this discussion. Nurses also may not take time (even if they have the time) for this discussion (Magnum, Reynolds, & Galvin, 2006).

Differences in religious values and cultural beliefs between nurses and patients add anxiety about approaching sexuality. Embarrassment and lack of experience also serve as barriers (Maurice, 1999; Monturo et al., 2001). Nurses must develop self-awareness of their values, attitudes, and feelings about sexuality as well as cultivate a nonjudgmental attitude toward patients with different values (Darst, 1988; Monturo et al., 2001).

To become comfortable (desensitized) in discussing sexuality and using sexual terms, nurses may express feelings and attitudes through discussions and/or writing. Nurses can practice sexual assessment questions in front of a mirror or with a colleague, and use the questions in every patient assessment. Repetition and structure decrease anxiety (Monturo et al., 2001). When anxiety arises during sexuality discussions nurses are encouraged to manage by maintaining a relaxed posture, deep breathing, and low voice tone or silence. Build rapport and use empathic skills to help patients manage anxiety (Darst, 1988; Monturo et al., 2001).

Maintain a comfortable and encouraging attitude about patients’ and partners’ ability to cope with the change in their sexual functioning and maintain sexual interaction without intercourse. Communicate knowledge that others have adjusted, and found that sexual intimacy is possible even though changed. As the conversation unfolds respond to the individual differences in the patients/couples, helping them to maintain their quality of life (Darst, 1988; A.M. Doyle, personal communication, June 2007).

Patients and spouses/partners who have been given instructions to continue sexual stimulation (“use it or lose it” message) feel pressure to work toward achieving an erection and need reassurance and instruction to relax. They need to hear a health professional say that the sexual stimulation should be enjoyable, unpressured, and not to expect an erection for some months (A.S. Norris, personal communication, June, 2007).

**Sexuality Assessment**

Provide privacy and a comfortable setting for the overall assessment, and initiate the topic of sexuality by indicating these are questions asked of all patients. Specific questions about sexual functioning clarify preoperative functioning level and provide realistic expectations for return of erectile ability postoperatively. Respond to nonverbal and verbal cues to build rapport (Monturo et al., 2001).

Assessment questions include:

- Are you sexually active?
- Do you have a sexual partner?
- “Is sex important to you and your partner?” (Penson et al., 2000, p. 338)
- How important are erections in your sexual relationship? (Monturo et al., 2001)
- How often have you had sexual penetration or intercourse in the past month?
- Is your erection sufficient for penetration and/or intercourse?
- Rate the firmness of your erection on a 0-5 scale, with 5 being the best.
- Are you satisfied with your sexual activity?
- Have you talked to your sexual partner about the sexual changes after prostate surgery? (P. Smith, personal communication, October 2006)

A written instrument may be used for assessment. The International Index of Erectile Function (IIEF) is a short, 5-point Likert scale questionnaire which assesses sexual function and can be used for preoperative assessment of sexual functioning and later to assess level of recovery of sexual function (Rosen et al., 1997). Items on the IIEF include frequency of erections during sexual activity, hardness of erections, ability for penetration, maintenance of erections, and confidence in getting and keeping erections. The instrument has been useful as a result of its response specificity (from none to almost always having the identified function) and measurement reliability (0.70 to 0.90 internal consistency and 0.64 to 0.84 test-retest reliability). Construct validity (convergent validity = 0.75 and discriminate validity <0.01) has been established (Rosen et al., 1997).

**Sexuality assessments** represent sensitive topics for the patient/couple. Use of relationship building skills and an interactive style help patients and spouses/partners develop trust in the nurse or physician, so unvoiced concerns can be expressed (Monturo et al., 2001).

**Nursing Intervention**

The PLISSIT model guides nursing intervention in sexual disorders (Annon, 1976; Monturo et al., 2001). There are four levels to the PLISSIT Model: P = Permission; LI = Limited Information; SS = Specific Suggestion; and IT = Intensive Therapy. The first three levels fall within general nursing practice. Nurses decide which level is most appropriate for intervening with a particular patient, and also within the nurse’s level of comfort or ability.

**Permission**

Permission, introducing the topic of sexuality, tells the patient/couple that it’s ok to discuss sexual concerns. Permission to discuss sexual issues may prevent secondary problems after surgery, such as emotional withdrawal and decreased intimacy. Provide reassurance that patients are still sexual beings, have a right to sexual pleasure, and have
options for continuing previous sexual activity and relationship(s). Include the patient’s wife or partner if possible, who may reassure the patient about his personal and sexual attractiveness and offer support for altering sexual interaction in the future (Penson et al., 2000). If relationship tensions appear, offer a referral for relationship and sexual counseling.

Dispelling myths, including (a) sexuality is a mystery and cannot be understood, (b) sexual behavior is natural and needs no effort or discussion, or (c) “once it’s gone, it’s gone” (Penson et al., 2000). These beliefs prevent exploration of alternative methods for sexual pleasure when full erections aren’t possible. An emphasis on erection and orgasm (stair step approach to sexual pleasure) interferes with sexual adjustment, increasing negative self-perceptions. Dispelling myths reframes thinking about sexuality, allowing a couple to work creatively to enhance sexual pleasure (Darst, 1988; Maurice, 1999).

Encourage the couple to accept comfort and reassurance from each other, and to appreciate their relationship and history. Discuss sexual adjustments as part of their history and relationship, as well as in the context of sexual development over a lifetime. When they developed secondary sex characteristics it was new and different. As adolescents, they adjusted to changing physical/sexual sensations and at some point learned how to give and receive sexual touch. As a couple they learned to engage sexually for mutual pleasure. This change is yet another adjustment and can be approached as a change in their sexual life rather than the end of intimacy (Darst, 1988).

Limited Information

Limited information (part 2 of the PLISSIT Model) is to provide information relevant to the sexual situation in general, and specifically to the patient’s situation. Patients and spouse/partner need information about expected sexual functioning, including:

- You won’t have an erection for at least 3 months.
- You may have gradual return of erections up to 2 years after surgery, which is not always recognized (Michl et al., 2006).
- There is a full range of sexual activity and expression for you and your spouse/partner to use in maintaining intimacy during this time (Monturo et al., 2001).

Help patients/couples label their reactions/feelings (shock, anger, fear, hopelessness) by noting nonverbal cues (Monturo et al., 2001). Some will feel they have encountered two life-altering experiences: once with a perceived life-threatening diagnosis of cancer, and second with the threat of lost sexual ability. Listen to patient/couple reactions; explore attitudes toward sex, lifestyle, and relationships; and ask about their expectations for sexual functioning after surgery.

Provide education in the client’s language, but clarify terms so there are no misunderstandings. Inquire about the terms the couple uses for erection and penetration or intercourse, and be sure the nurse and patient are talking about the same thing. If communication is difficult, use diagrams for explanations (Darst, 1988). Penson and associates (2000) recommend both pre and post surgery discussions to help patients and spouses/partners cope with sexual changes.

Discuss sexual changes within the framework of the sexual response cycle, using a simple diagram resembling a small hill. The start of the hill represents sexual desire or interest, fantasies, and the wish or intention to be sexual. Sexual desire may be vulnerable to discouragement about erection problems. The rise in the hill represents sexual arousal, with pleasurable sensations and the closeness of physical contact with one’s partner (more important than judging the quality of an erection).

Encourage couples to enjoy the increasing and subsiding of sexual sensations (Darst, 1988).

Identify the top of the hill as the orgasm which is possible after prostatectomy, even without erection or ejaculation. This peak sexual sensation of intense pleasure happens spontaneously without willing it and is followed by intense relief. Sexual pleasure and intimacy (the purpose and joy of sexual involvement) are possible without orgasm. The downward slope of the “hill” represents a relaxed pleasure lingering after sexual activity; a time for emotional intimacy and mutual caring. This phase sometimes becomes a time when discouraged partners turn away from each other, feeling they were sexually inadequate, unable to meet their partner’s or their own expectations. Encourage couples to communicate about their feelings rather than withdraw, hold each other, and enjoy the physical comfort and closeness. Throughout these explanations engage the couple and ask for their ideas about how they can continue sexual intimacy without intercourse (Darst, 1988).

Discuss the surgical options and provide information about nerve-sparing surgery. Advocate for patients with the physician to preserve sexual function. Some couples may choose less intervention with decreased life expectancy to preserve quality of life for their remaining years. Some will choose modest goals after surgery, not using sildenafil or other methods of enhancing erections (Monturo et al., 2001; Schover, 2000). Explore patients/couples feelings about using sildenafil or other methods of promoting tumescence (intracavernosal injections or vacuum pump). Educate about using sexual stimulation along with the medication, and focus on the sexual sensations rather than worrying about erection. Sildenafil requires assistance to work well (Neese, Schover, Klein, Zippe, & Kupelian, 2003). Sildenafil should be avoided after heavy meals or drinking alcohol (Neese et al., 2003).
Explain factors that affect return of erectile ability (such as previous sexual activity, prior erectile ability, nerve-sparing surgery, and co-morbidities). Regular sexual activity enhances return of erectile potential. Help the couple engage in sexual activity with a sense of relaxation and pleasure rather than pressure or achievement. Correct any misconception that erections will be better than they were before surgery. Erectile problems before surgery are caused by some other condition, not the prostatectomy. Other conditions (diabetes mellitus, hypertension, medications) need assessment to determine treatment outcomes for ED.

Encourage patients/couples to resume sexual activity by expressing affection and substituting alternate sexual activities and caressing rather than intercourse (Darst, 1988; Neese et al, 2003; Schover, 2000). Discuss attitudes and feelings about using nongenital caressing, sexual stimulation with one’s hands, and oral genital stimulation. Emphasize pleasure and closeness rather than erection and orgasm, also helping men understand women’s sexual responsiveness to these approaches (Darst, 1988).

Discuss retrograde ejaculation (dry orgasm), in which the ejaculate flows into the bladder rather than through the penis at the point of orgasm, another result of prostatectomy (Monturo et al., 2001). Orgasm still happens, but sensations may be different than previously as the ejaculate does not flow through the penis. Suggest the use of lubrication products, available in drug stores, to ensure lubrication sufficient for penetration and/or intercourse, if erectile ability is still intact. Lubrication promotes comfort for a female partner as well.

**Specific Suggestion**

Specific suggestion (Canada et al., 2005), the third level of intervention in sexual problems, requires comfort in discussing sexuality with patients and willingness to take time. Providing specific behavioral suggestions can significantly impact patients’ and couples’ ability to maintain or improve sexual satisfaction. One or two sessions may be sufficient (Fogel & Lauver, 1990; Monturo et al., 2001) and should be conducted in a quiet, confidential area. Initiate discussion of recommended behavioral interventions to implement at home, with individual client characteristics considered. All clients do not respond to the same therapeutic techniques due to style of learning and defense systems. Some learn by exploration and others may have difficulty focusing (A.M. Doyle, personal communication, June 2007).

Discuss the couple’s emotional reactions to behavioral suggestions, and clarify those reactions with empathic listening. Explore negative reactions that would interfere with progress, and clarify misinterpretations. Ask how the couple might implement the behavioral suggestions, encouraging them to individualize suggestions to fit their unique sexual relationship. Inquire about factors that might interfere with implementation, and modify recommendations to fit a specific individual or couple (A.M. Doyle, personal communication, June 2007).

**Sensate focus 1.** Sensate focus exercises are helpful suggestions (Althof, 2000; Darst, 1988; Schover, 2000). Instruct patients and partners to use full-body pleasuring without genital involvement and a focus on sensations. Engage in this activity at a time when both are rested. The couple should prevent interruptions by turning off the phone, television and radio, containing pets, and planning around visitors and their own fatigue. The assignment may be structured so one person gives to the other for 15 to 20 minutes, then exchanges for the next 15 to 20 minutes. This exercise can be followed by talking about what was most pleasurable to emphasize enjoyment and learn what pleases each other. Other options are to write about reactions and share with each other at a later time, or to hold a discussion later. Erection and intercourse are not expectations of this assignment. If an erection occurs, intercourse should not be attempted, to allow full focus on sensations without the pressure of performance and fear of being unable to perform. If intercourse is attempted prematurely and the erection is not sustained, the failure experience may interfere with building sexual confidence.

**Sensate focus 2.** Instruct patients/couples to use genital exploration, touching in various ways, and enjoying the sensations, always attending to the couples’ wishes and opinions. Use light touch, feathery touch, various pressures, and stroking in different directions. Use hands to touch during one session, and another time experiment using lips and mouth in touching genitals. Touch all parts of the genital area. The activity can be structured so the couple takes turns in being the giver and receiver, to help individuals maintain focus on the sensations, enjoyment of sensations, and building sensations. The receiver should keep his mind on the sensations, learning what provides the most pleasure for himself (and vice versa for the partner). When giving pleasure, a person learns what the partner likes. Focus on sensations may stimulate a partial erection and the couple should continue enjoying the sensations without pressure for full erection or intercourse. The couple learns to take time with sexual pleasuring, which for some is new learning (Darst, 1988).

**Mutual sensate focus,** a third set of instructions, allows for a focus on one’s own sensations as well as on giving pleasure and maintaining awareness of one’s partner. The focus should be on sensation building rather than on full erection or penetration/intercourse. Encourage the couple to continue this focus for the months following the surgery, until it is...
determined what level of erectile function will return. Emphasize the value of maintaining physical pleasuring and intimate physical expressions as helpful to the couple’s emotional relationship. Broadening the couple’s repertoire of sexual behaviors through these activities/exercises especially helps couples with “limited sexual scripts” (Rosen, 2000, p. 288).

Stuffing, placing a partially erect penis at the entrance of a female partner’s vagina and pressed into the vaginal opening, may be recommended for some couples. Since the vaginal opening has more sensation than deeper areas of the vagina, this activity can help stimulate vaginal sexual feelings. Men also learn that clitoral stimulation is necessary for female sexual pleasure, and for some is more pleasurable than intercourse. Clitoral stimulation does not require a male’s erection, perhaps decreasing the emotional pressure for erection after a prostatectomy. Many men do not understand female sexual anatomy and response to sexual stimulation, and this information can be helpful.

Caution patients to avoid emotional withdrawal from the relationship. Withdrawal may happen out of a sense of failure, diminished sexual self-esteem, body image concerns, a wish not to disappoint their partner, or a lack of alternatives to intercourse (Rosen, 2000). Suggest that couples express their own feelings of frustration and disappointment about the sexual change, as well as their concerns for their partner’s sexual pleasure. Hold these conversations at various times during the day rather than in bed, unless the feelings become overwhelming and cause emotional withdrawal during a pleasuring experience. Encourage the patient to remain independent and the partner to avoid a caretaking role, which can lead to marital conflict (Schover, 2000).

Couples often develop their unique ways of implementing these suggestions, using their creativity in maintaining their sexual and intimate relationship. The nurse must engage the couple in the discussions to develop an individualized, relevant approach to each couple.

**Intensive Therapy**

Unless trained as a therapist, a nurse’s role in this area is to refer for therapy. Signs that a referral is needed include (a) persistent negativism from the patient regarding specific suggestions, (b) obvious relationship conflict, (c) history of relationship problems and sexual conflicts, and (d) mental illness diagnoses or presence of depression. Nurses may also refer if they feel uncomfortable in providing guidance about sexual concerns. Make referrals to therapists the nurse and/or physician know and trust, which facilitates a smooth transition to specialized care. Communicate with the therapist to coordinate care, as sexual issues involve physical and psychological factors. Continue to assess the patient’s sexual functioning at followup visits.

Therapy for enhancing sexual functioning following prostate surgery has shown promise for decreasing overall stress, as well as improving global sexual functioning of patients and partners. Future randomized trials are needed to develop effective methods for maintaining gains. Sexual rehabilitation interventions outlined by Canada et al. (2005), include use of the PLISSIT model, communication and relationship interventions, and promoting sexual passion. Schover (2001) outlines brief sexual counseling as including “sex education, attitude change, suggestions on resuming sex comfortably, ideas on overcoming physical handicaps, and decreasing marital conflict that is illness related” (p. 414). These recommendations may be implemented by nurses working at the intensive therapy level. In addition, Canada et al. (2005) offers a therapist manual as a guide, and Rosen (2000) addresses specific treatment approaches and issues.

**Conclusion**

Direct, frank talk about sexual changes assists patients and spouses/partners adjust to changes following prostatectomy. Nurses must offer a trusting relationship in which to provide guidance for sexual issues, helping patients use their creativity in maintaining sexual activity and intimacy. Future studies are needed to answer questions about the best times to intervene with patients facing a prostatectomy, as well as what topics and interventions should be initiated at which times. Additional studies would be helpful to identify the most effective methods of assisting nurses to incorporate sexual assessment and counseling in their practices.

**References**


Additional Readings


