Tackling the SEX TABOO

Nurse Lorraine Grover is keen to change attitudes to sexual dysfunction, reports **Emma Vere-Jones**

‘WE DID it!’ read the text message. For Lorraine Grover, a clinical nurse therapist in sexual well-being, it was welcome news. A couple she was treating had managed to have sex for the first time, thereby consummating their year-old marriage.

Their problem is not as uncommon as it may sound. Sexual dysfunction affects around one in ten men, according to the Sexual Dysfunction Association, which also suggests 50% of women will experience some sort of sexual problem such as loss of desire or arousal, difficulty reaching orgasm or pain during intercourse. But getting good data on the subject can be tricky because of the stigma surrounding it. People don’t want to talk about their sex lives – and it’s not just a problem for patients. Lorraine explains that clinicians also find it tricky to tackle the subject of sex.

‘Sometimes I think clinicians are fearful of their own lack of knowledge – although often they have more knowledge than they think,’ she explains. ‘Doctors and nurses may have their own inhibitions, fears and misconceptions regarding sex that limit their ability to discuss issues with patients.’

So for the last decade Lorraine has been on a mission to get clinicians and patients talking about sex. Her interest was first sparked when she took a part-time job as a urology research nurse in 1994.

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‘While I was working as a research nurse I was seeing patients with erectile dysfunction (ED) and they would talk a lot about the impact ED had on them and their lives,’ she says. ‘I realised it was an area that we just didn’t normally discuss.’

What started as a two-day-a-week job has developed into a full-time career. Lorraine now spends three days a week running clinics at St George’s Healthcare NHS Trust in London and Buckinghamshire Hospitals NHS Trust. The other two days she works in private practice, dividing her time between a clinic on London’s Harley Street and work closer to home in Buckinghamshire.

Robert Greshoff

The majority of her patients are men and she sees a wide range of people from patients with cancer and diabetes to those on statins or victims of car accidents. She offers holistic care – something that is often lacking from other parts of the service.

‘In medicine there’s a real focus on the disease and it’s the disease that clinicians are managing, not necessarily the impact it may be having on quality of life, including sexual function,’ Lorraine points out. ‘For example, men may have their prostate removed for prostate cancer, so the cancer may be gone but the outcome is often ED. So from the surgeon’s point of view it’s “We’ve got rid of the cancer, what are you worried about ED for?”. I can give patients more holistic care and a better quality of life by addressing the sexual dysfunction.’

The impact of sexual dysfunction on a patient’s life can be very profound but too often it is underestimated, Lorraine says. ‘I had one man who was suicidal and I had to refer to the on-call psychiatrist. I’ve seen other men who have said “I wished I’d never had surgery. I’d rather live a full shorter life than not be able to have sex”.’

The good news is that, for most, problems can be cured and treatment for men has come a long way in the last 10 years. ‘Oral pharmacotherapies have now transformed the management of ED. Before they became available there was only injection therapy and vacuum devices. That could be why some people didn’t seek help, because those options weren’t as user-friendly even though they are effective,’ Lorraine explains.

But she admits that drugs are just one piece of the puzzle when it comes to curing ED. ‘While there are fantastic drugs now available you’ve got to remember that the penis is attached to a man who may be in a relationship and the drugs won’t sort out emotional or psychosexual issues,’ she says. ‘Sexual dysfunction can have a significant impact on a patient whether or not they are in a relationship.’

Treatment for women can also be tricky, she says. ‘From a women’s point of view there doesn’t seem to be such an obvious quick fix such as taking a tablet. With women there can be many factors that impact on their sexual function. For example, issues regarding desire and the arousal process. It is often not as easy to manage as it is with men.’ There are also fewer services for women, she adds.

One of the keys to ensuring successful treatment is helping people as early as possible, Lorraine says. It is important to warn patients before they get treatment that may adversely affect sexual function because there are things they can do in recovery to prevent it, she explains.

Lorraine also spends a lot of her time lecturing clinicians on sexual dysfunction. She says it is important for them to broach the subject with patients rather than waiting for patients to ask for help, and suggests the phrase ‘in my experience’ can be a useful one for tackling the subject. As she explains, ‘If you say, “In my experience patients who take these drugs sometimes experience problems, please let me know if that happens”... [and] a patient doesn’t feel comfortable talking to you there and then it gives them an olive branch to think, “Next time I’ll pluck up courage to say something.” It is also non-confrontational.’

In a further bid to get conversation flowing, Lorraine developed an information pack – *The Erection Connection* – for clinicians. Developed with a grant from the Queens Nursing Institute, it includes a CD-ROM and a flipchart for clinicians to use.

‘There can be hesitancy to discuss sexual problems with patients as they do not know what to say. By having something such as a flip chart in the room it’s a visual trigger to make people feel they can talk about problems. It can also be used by clinicians as an information package/CD-ROM to use with or give to patients.’

She hopes the resource will be launched nationally in primary and secondary care.

For those prepared to tackle the subject, the rewards for patient and clinician can be great. ‘One guy emailed me last week to say, “Thank you, I didn’t think anyone would ever be able to help me,”’ Lorraine says. ‘I’d say most weeks I get feedback from people who say how helpful it has been. You just have such positive outcomes.’ ■

WHAT YOU CAN DO TO HELP

- **If you have a patient on treatment that may adversely affect sexual function, raise the subject with them rather than waiting for them to ask you**
- **Try using the phrase ‘in my experience’. For example, say ‘In my experience, people receiving this treatment sometimes experience sexual problems’**
- **If you don’t have the skills to help someone, use extra support from external charities such as Relate**
- **Share the advice and knowledge with other clinicians and seek support from other colleagues when trying to improve care for patients in this area**