Multiple sclerosis (MS) is a progressive disease affecting the central nervous system. There are currently four recognized subtypes of the disease, defined according to the frequency and severity of symptoms; MS can have a relapsing–remitting course, with exacerbations followed by periods of remission, or it can progress without remission, although relapsing types usually cause more damage and remission periods shorten over time. MS most commonly appears between the ages of 20 and 50 years. Although some people have relatively few problems, others will be severely affected; disease progression can be rapid or more indolent. All aspects of daily life may be affected, including sexual functioning, which may be altered as a result of changes in muscle strength; problems with bladder and bowel functioning; and altered sensation, particularly in the genital region.

**HOW IS SEXUALITY AFFECTED?**

A 2006 study by Demirkiran and colleagues showed that more than 80% of patients with MS experienced sexual dysfunction. Foley and colleagues developed a conceptual model of sexual difficulties in people with MS that comprises three levels. In this model, primary sexual dysfunction occurs as a result of neurologic changes directly affecting sexual response or feelings (or both). According to a study by McCabe and colleagues, women most commonly describe altered genital sensations, diminished vaginal lubrication, difficulty achieving orgasm, and a loss of desire. Men experience difficulty achieving and maintaining erections as well as ejaculatory problems (failing or taking too long to ejaculate; the rate of premature ejaculation in the study wasn’t statistically different from that in the general population). Secondary sexual dysfunction is caused by MS-related physical changes that don’t directly affect sexual functioning through nervous system pathways. Examples of these are fatigue and bladder and bowel problems. Tertiary sexual dysfunction refers to the psychosocial aspects of the disorder that can significantly affect sexual functioning, such as body image, mood, and sexual self-image. Dysfunction at any of these three levels can be distressing to a patient, however, and several of these are worth noting.

**SEXUAL CHALLENGES IN MS**

**Fatigue** is experienced by as many as 95% of patients with MS and can have several causes. Energy is used in coping with activities of daily living and with temperature changes in the environment, particularly heat, which are often taxing to patients with MS. Muscle spasticity (involuntary muscle stiffness) also consumes energy, and people with symptomatic MS are usually very tired at the end of
the day. This can mean that they lack sufficient energy for sexual activity. The nurse working with such a patient may want to make some suggestions for conserving energy or dealing more effectively with the lack of energy. A referral to physiotherapy or occupational therapy may be in order; such therapists can provide strategies for energy conservation during daily activities, which may stimulate greater interest in sexual activity. Patients with MS may be able to identify the times of day when they have the most energy (perhaps after a nap or early in the morning) in order to engage in sexual activity. The use of stimulants such as caffeine can be counterproductive because they can cause bladder irritation, bladder spasms, or incontinence. Alternative positioning for sexual intercourse may be helpful, too; the side-lying and bottom positions use less energy. Alternatives to intercourse (such as oral sex) may also use less energy and provide satisfaction for both parties. 

**Bladder and bowel concerns.** One possible challenge during sexual activity for the person with MS is incontinence, either urinary or fecal. Even if it has never occurred, the patient’s fear may be so great that she or he avoids sexual activity altogether—“just in case.” If the person with MS cannot empty her or his bladder completely, there may be pressure in the pelvic area that interferes with

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**Having an indwelling catheter doesn’t preclude sexual activity.**

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**The PLISSIT Model of Treatment**

**Permission.**
Give the patient permission to discuss sexuality. All nurses should be able to function at this level. They can include a general statement in the conversation that normalizes the topic.

- Example: “Many women with MS notice some changes in sexual functioning. I would be happy to talk to you about this at a time that suits you.”

**Limited Information.**
Provide enough information to help the patient function sexually. Erectile difficulties are common in men with MS, and basic information can be helpful. Most nurses should be able to give this kind of information.

- Example: “Men with MS often notice some changes in their ability to achieve and maintain an erection. This is due to nerve damage, but there are medications that may help.”

**Specific Suggestion.**
Requires a deeper level of expertise on the part of the nurse, who must be able to provide anticipatory guidance on the possible sexual consequences of the disease and its management.

- Example: “I understand that you occasionally have some leakage of urine during sexual activity. Emptying your bladder just before sex can help. But remember that urine is sterile and the leakage is probably more embarrassing to you than it is to your wife.”

**Intensive Therapy.**
Usually requires a referral to a sex therapist or specially trained counselor. Nurses should know where to refer patients when problems or issues are disclosed that are beyond their scope of practice or expertise.

- Example: “Your wife has shared with me that you’re having some difficulties talking about the challenges of living with MS. Our social worker has a lot of experience in this field, and she’d be happy to see you both and provide some guidance to you.”

sexual pleasure. Emptying the bladder completely just before sexual activity can help with this. Restricting fluid intake and avoiding diuretic beverages such as coffee and diet soda may also help.

Passing flatus or leaking feces during sexual activity can be very embarrassing. In addition, constipation can make intercourse uncomfortable. Careful use of laxatives and stool softeners may help, although it’s important to avoid diarrhea, which may itself cause fecal incontinence. Some people with MS may need manual extraction to empty the rectum of feces. Catheters. Some people with MS have an indwelling catheter, which might appear to completely preclude sexual activity, but for the motivated couple sexual intercourse is possible; women should bring the catheter forward (away from the vaginal introitus) and tape it securely to the leg; men can bring it backward along the length of the penis and anchor it in place with a condom. Friction may cause irritation to the urethra for both men and women so stabilizing the catheter is important.

Muscle spasm and spasticity. Some people with MS experience muscle spasms or spasticity (or both), which can directly affect their ability to participate in pleasurable sexual activity. Muscle spasms usually occur without any warning, and the pain will definitely interfere with any pleasurable activity. Spasticity may interfere with comfortable positioning. Medications such as muscle relaxants and antiseizure agents can treat

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**The BETTER Model of Treatment**

**Bring up the topic.**
Raise the issue of sexuality with patients.

- Example: “Many people with MS notice some changes in their sex lives over time. What kind of changes, if any, have you experienced?”

**Explain that sex is a part of life.**
This helps to normalize the discussion and may help the patient to feel less embarrassed or alone.

- Example: “It’s not uncommon for men with MS to have difficulties having an erection. I’d like to spend some time talking with you about this and any other concerns you may have.”

**Tell patients that resources are available to address their concerns.**
Even if the nurse doesn’t have an immediate solution, others can help.

- Example: “You’ve asked an important and interesting question, and I don’t have the answer right now. I’ll talk to the clinical nurse specialist about this and call you with her response.”

**Timing of intervention.**
Let patients who aren’t ready to deal with sexual issues know that they can ask for information in the future.

- Example: “We can continue our conversation about this when you’re feeling better. I’ve made a note of your concern, but please also remind me at our next appointment.”

**Educate patients on sexual adverse effects of treatment.**
Informing patients about possible sexual adverse effects of treatment is as important as informing them about any other adverse effects.

- Example: “The medication for depression that your physician has prescribed can sometimes interfere with sexual arousal.”

**Record all assessments and interventions in the medical record.**
A brief notation in the patient’s file that a discussion about sexuality or sexual adverse effects took place is important.

- Example: “Possible sexual adverse effects of treatment discussed. Patient was given the opportunity to ask questions and was referred to the social worker.”

both of these symptoms, but they’re often sedating. Taking medication about 20 minutes before sexual activity may be helpful.

Experiencing with different positions can also help the couple find a way to be sexual without causing problems caused by MS itself or create new ones.²

**Body image difficulties.** MS causes changes to the physical body resulting from muscle wasting, weight gain (a consequence of inactivity), and mobility issues. For many with this disease, this can cause a negative body image.³ Not everyone experiences this, but some patients may feel unattractive and undesirable, further challenging any hope of an active and satisfying sex life. Body image issues can affect even long-term relationships and can cause significant distress to both the person with MS and the partner.

**References**


