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Practical strategies for the management of sexual problems in Parkinson's disease

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SUMMARY

Introduction: Patients with Parkinson's disease (PD) report frequent sexual dissatisfaction, desire, arousal and orgasmic problems. Motor and non-motor symptoms contribute to further manifestations of sexual dysfunction (SD). Studies have indicated that the need for intimacy and sexual expression are important dimensions of quality of life for PD patients. Inquiry about sexual functioning may be overlooked by neurologists due to time constraints, confusion about sexual conversation, and lack of proper training.
Methods: Practical strategies will be presented. "Open Sexual Communication" (OSEC) module will be used to overcome barriers for sexual discussion. Suggestion for further assessment and analysis of cases will enable understanding of specific sexual interventions adapted for PD patients.
Results: Physicians will be empowered to address sexual problems of PD patients and encounter a range of practical interventions.
Conclusions: The physical and emotional changes in PD and treatment of the disease have a major effect on SD of patients and their partners. All patients may experience impairment of sexual function and quality of life. Health care providers can proactively address sexual health issues by providing information, by recognizing and treating the sexual needs of PD patients and by referring them to specialists.

1. Introduction

Sexual dysfunction (SD) is common in Parkinson's disease (PD) and frequently patients report sexual dissatisfaction [1–3]. SD occurs as a non-motor manifestation of the illness, but is often compounded by secondary problems relating to physical disability, psychological factors and medication effects. PD symptoms, especially movement disorders, reportedly contribute to a general deterioration in sexual functioning in 33 (76.7%) men and 25 (78.1%) women who are sexually active [1]. SD rarely threatens physical health but can take a heavy psychological toll. Quality of sexual life (QoSL) in PD is significantly correlated with patients' general satisfaction from life [4]. Despite the disabling effect of SD in PD, it is still one of the most poorly discussed issues with the sexual partner [1] and one of the underrated and less investigated aspects of the disease [2].

SD is also a prevalent problem in the general population [5,6]. The majority of those experiencing SD refrain from seeking professional help [7–9]. Significant barriers in physician communication with patients overstay despite the increasing awareness of the accessibility of effective treatments and are responsible for a low report rate of sexual dysfunction [8–10]. The complexity of the illness, time constraints, confusion about how to initiate the conversation, and lack of proper training may explain this professional limitation [11]. Patients' reaction to physicians addressing sexual health is positive and characterized by willingness to communicate, and relief that their sexual problems have been addressed [10].

In the past SD was considered a complicated condition requiring a specialist, and there has been a limited emphasis on physicians' sexual education. Today physicians may encounter information on sexual medicine interventions [12–14]. It is thus the purpose and the focus of this manuscript to empower physicians, who wish to address the topic of sexual health during the routine office visits of their PD patients and initiate direct discussions regarding their sexual well-being and concerns.

2. Practical strategies paradigm

Practical strategies for the clinical management of sexual problems of PD patients will be demonstrated in three phases. Phase 1 will offer the "Open Sexual Communication" (OSEC) module (algorithm in Fig. 1), a four-step-tool to assist clinicians to initiate sexual discussion with patients and identify their concerns. Phase 2 will offer practical tools for evaluation of the sexual problem. Phase 3 focuses on practical interventions and solutions for sexual problems.

The underlying principle of this paradigm is that each physician can choose the level of intervention which corresponds to his

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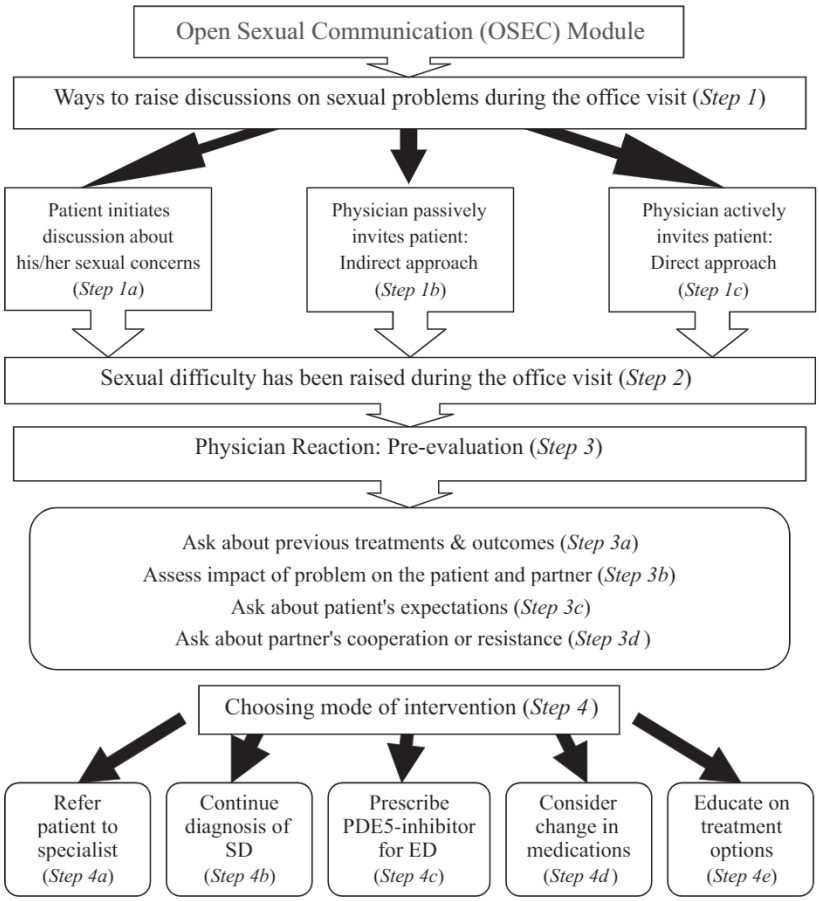

Fig. 1. Algorithm, Open Sexual Communication (OSEC) module.

personal capabilities and time constraints. It is important to stress that each step of action is beneficial. For example, by referring a patient to a specialist, the physician acknowledges the importance of the sexual concerns. This recognition may have a relieving effect on the patient and the partner.

2.1. Phase 1. "Open Sexual Communication" (OSEC) module

Upon realizing that SD can profoundly affect the life of patients with PD and their partners, and upon understanding that frequently patients are too confused to share their sexual concerns, clinicians can best serve their patients by routinely initiating discussions about sexual function during clinical visits. Addressing sexual issues in the office setting requires a comforting and secure atmosphere in which patients can easily discuss their intimate problems. The "Open Sexual Communication" (OSEC) module (Algorithm 1) will assist clinicians instigate conversation. Step 1 of the module suggests three options to open a sexual discussion during a routine office visit. The first is when the patient spontaneously brings up the sexual health concern (step 1a). The other two place the responsibility on the physician. The indirect communication approach (Step 1b) is a passive suggestion inviting patients to present their sexual concerns. This step is easily implemented by distributing leaflets, posters, questionnaires and other relevant information in the clinic [15], and evokes a high help-seeking behavior.

In the direct approach (Step 1c) the physician actively asks one of the following inquiries: "*How did your illness affect your intimate life?*" or "*Are you experiencing any problems with your sexual function?*". He may make patients feel that sexual problems are frequent, by saying: "*Maybe you are unaware, but people with PD often have problems with sex. If you notice any changes in your sexual life, please share with me. Today we can treat many sexual problems*."

It is best for the clinician to develop a technique that can be comfortably used with most patients, although sometimes a flexible approach is needed depending on factors such as patient's age and cultural background, the clinician's familiarity with the patient, the presence of the patient's spouse, and the nature of the specific visit.

Once a sexual problem has been presented (Step 2), the physician may advance to Step 3 or skip directly to Step 4. Step 3 is a pre-evaluation step, designed to collect relevant information before deciding on further action. The information is collected using four inquiries (step 3a to 3d): Detailed description of previous treatments and consequences (e.g. medical treatments, over the counter drugs, psycho-therapy, and sex therapy); the impact of the problem on the patient and partner's life; the patient's expectations and priorities regarding further counseling; and the partner's involvement, cooperation or resistance to solve the sexual problem.

Step 4 includes a variety of options for action, e.g: referral to a specialist; continuing diagnosis of sexual problem; prescribing a PDE5-inhibitor for ED; changing medications; educating patient on treatment options, or handing written information. The information gathered in step 3 may support the physician's choice of an appropriate intervention in step 4.

For example: If a patient with ED has already failed medications (PDE5-inhibitors the physician can refer him to a urologist (to evaluate the physical aspects of ED) and to a sex therapist (to evaluate the sexual-psychological aspects). If a patient complaints on a non- cooperative spouse, the physician may invite her to assess her difficulties. If the patient is stressed, the physician may set a sex

Box 1. Sexual History: list of issues relevant to the assessment of sexual problems in Parkinson's disease

Ask your patient and/ or the patient's partner about:

1. The onset of the sexual problem
2. The progression of the sexual problem
3. The nature of the problem:
   a. Generalized and constant
   b. Situational and specific
4. Evaluate the specific situations when the sexual problem exists, according to:
   a. Timing of sexual activity (morning, evening, weekend, etc.)
   b. Type of activity (self stimulation, manual or oral stimulation, masturbation)
   c. Partner (steady, occasional, present or past partners).
5. Description of sexual function and sexual satisfaction before onset of PD.
6. Psychological or interpersonal or relationship factors.
7. The most bothersome sexual problem: desire, arousal, erectile, early or delayed ejaculation, orgasm, pain, frequency of sexual activity, cooperation of partner.
8. Sexual problems of the partner (use items 1, 2 and 3 above).

education session to explain the correlation between PD symptoms, medications and sexual function.

2.2. Phase 2. Practical strategies for evaluation of sexual problems

Clinicians who choose to proceed with assessment can achieve higher success rates by including the partner in the discussions and treatment planning [13]. There is a significant association between male and his female partner's sexual function. ED has significant adverse effects on the female partner's sexual function [15] and treatment of ED may lead not only to improved male sexual function, but to improved relationship [16] and improved partner's sexual functioning [15]. By taking sexual history (Box 1) patients get an opportunity to discuss their sexual problem in a non-threatening manner. Communication between physician and patient may be enhanced by placing the sexual history in an appropriate context in the medical history process. Sexual history should include investigation about pre-morbid SD which might effect the present sexual functioning of the PD patient. In a study of 75 patients with PD (32 women), pre-morbid SD explains cessation of sexual activity among 21.9% women and 23.3% men [1].

A convenient alternative for rapid evaluation of SD may be achieved by the use of abbreviated questionnaires [10,17,18]. Use of questionnaire by physicians has high level of acceptance by patients and prompts sexual discussions [10].

The Arizona Sexual Experience Scale (ASEX) [17] is a convenient five-item rating scale that quantifies sex drive, arousal, vaginal lubrication/penile erection, ability to reach orgasm and satisfaction from orgasm in men and in women. The ASEX can be used by clinicians as a direct communication tool (Step 1c), to improve the level of comfort in initiating and discussing sexual issues [19]. Patients can fill the ASEX questionnaire in the waiting room (Step 1b) and handle them to the physician during their visit. The ASEX can be easily interpreted, making it an efficient tool to evaluate the severity of SD (Step 4).

Another effective and convenient tool is the Sexual Health Inventory for Men (SHIM), an abbreviated questionnaire for the diagnosis and the severity of ED in clinical settings [18]. The moderate-to-high correlation between the SHIM and patient self-assessment of ED validates the SHIM for use [18].

2.3. Phase 3. Practical strategies for managing sexual problems in Parkinson's disease

Both organic and psychosocial factors play a role in the etiology of sexual function and dysfunction, and consequently in the management and treatment of SD [20]. Our clinical experience demonstrates that frequently anxiety or inability to discuss sex can severely complicate a presenting picture of even a mild organic deficit, quickly escalating it into a complete and total SD. Analysis of the following cases will demonstrate the underlying factors of sexual problems in PD from a sexual perspective and propose practical solutions. The overall goal of these interventions is to increase intimacy, pleasure and satisfaction, rather than achieve a perfect genital response. For many couples it is surprising to discover how enjoyable sexual activity can be, in spite of the limitation imposed by PD.

3. Case 1. Aging, erectile dysfunction and vaginal dryness

A married 72-year-old man diagnosed with PD 15 years ago complains of deterioration in his erectile function. He has been using successfully PDE5-inhibitors for 3 years, but lately he can't get a firm erection for intercourse. He and his 70 years old wife have good relationship and desire to maintain their sexual activity. They have wondered: "*Maybe we are too old for sex?*" and "*Do we have to give up sex?*."

The sexual counseling proposes the following interventions:

1. The couple receives a reassurance that they have the right to stay sexual.
2. Description of natural changes in sexual response that occur with aging, encourages them to adjust their sexual activity to these changes (e.g. focus on direct stimulation of the penis and the clitoris to achieve better arousal.)
3. Diagnosis of vaginal dryness and reduced lubrication leads to advising on the use of lubricants, in order to prevent sexual pain which may lead to reduced female sexual desire.
4. The man is referred to a urologist for re-evaluation of his ED treatment.
5. Teaching the Intercourse-Outercourse approach [11], a pleasuring sexual activity alternatives, enables the couple to have intercourse or alternatively enjoy a variety of erotic activities without inserting the penis into the vagina (outercourse). They can reach orgasm by genital rubbing, oral stimulation or manual

stimulation. The outercourse activity enables erotic pleasure without being distressed by the firmness of the erection or the inability to penetrate the vagina.
6. The man is offered to have intercourse only when he was using a PDE5-inhibitor.
7. The couple is encouraged to share their sensations and create open sexual communication.

4. Case 2. Sexual desire gap within the couple

A 59-year-old married man with PD complains that his 58-year-old wife suffers from low sexual desire. A separate session with the woman reveals that her husband was daily courting or demanding sex politely. She was thankful for the opportunity to confess that his sloppy appearance, his awkward speech made him unattractive for her. She explains that due to his motor symptoms she had to take an active role during intercourse (e.g. manually stimulate his penis). In spite of all the difficulties, she still loves and cares for him and is ready to have sex twice a week. But his daily nagging has affected negatively her motivation to have sex with him at all. During a separate session with the man, we find that his self esteem is low, due to his physical and social limitations. Having sex is a symbolic act for him to prove his masculinity and gain her love.

The sexual counseling includes the following interventions:
1. Broaching her difficulties in emphatic setting has a relieving psychological effect for the woman. She is grateful that her efforts to normal intimate relations are appreciated.
2. He is instructed to reduce the frequency of intercourse to twice a week.
3. In order to make him feel attractive and sexually active, we suggest touching assignments [21] in a non-demanding way, namely, without impelling intercourse. The non-demanding touch is an efficient tool to increase intimacy and desire.
4. A discussion with the patient on other options for his sexual release leads to a suggestion for self-touching (masturbation), which he is willing to accept.

5. Case 3. Retarded ejaculation or inhibited orgasm

A 60-year-old divorced man diagnose with PD since 12 years, complains of delayed ejaculation: "*I have a 10 years younger partner with whom I enjoy to have sex. We meet once a week and most of the times I have good erections and my sexual desire is high. The problem is that I rarely reach orgasm. I try very hard, but after 30–40 minutes I get tired and sometimes lose my erection. I'm frustrated and lately my desire to have sex is decreasing.*"

Our sexual counselling consists of the following advice:
1. Sexual history reveals that he is using SSRI's, due to uncontrolled tears shedding.
2. His partner says that she is very satisfied with sex and can reach orgasm. However, she wishes to reduce the duration of intercourse. She notices his frustration.
3. We explain the association between SSRI's use and retarded ejaculation [22].
4. To prevent the negative effects of retarded ejaculation on reduced female desire, female sexual pain and male erectile dysfunction, we suggest to limit penile penetration time. The woman agrees that 10 minutes of intercourse are acceptable for her. The man is requsted to withdraw, independently of his orgasm.
5. A once a week session of non-demanding intimate touching is offered to the couple, to provide them with an opportunity to enjoy physical closeness without any tension.
6. The man is recommended to attempt reaching orgasm by oral or manual stimulation.
7. In the follow-up session the couple reports that manual stimulation (by the man or his partner) is an efficient way to reach orgasm in half of the times.
8. If reaching orgasm is impossible due to the use of SSRIs, a consultation with a psychiatrist is necessary. The psychiatrist may change the medication or recommend a "medication weekend vacation" to enable some men reach orgasm during the break.

6. Case 4. Erectile function and motor symptoms

A married 45-year-old man complains of ED: "*When we touch one another we get aroused. I have a good erection. I stimulate my wife until she is satisfied. Then I try to insert my penis and I lose erection. My family physician has prescribed a medication. I've used Viagra and also tried once Cialis and even a Levitra. Nothing helped. I'm so helpless and distressed. What can I do?*"

Our sexual intervention included the followings:
1. The couple is instructed to shift from intercourse to outercourse, in order to reduce stress and increase pleasure.
2. A detailed sexual history reveals that the ED occurred when the man tried to mount his wife in the missionary position. Due to his motor limitations, the effort exerted in changing a position leaves him without erection. We have suggested to stay in a position which enables penetration, e.g. a side-by-side, a spoons or a woman on top positions.
3. Sexual history reveals that the man tried to have sex too soon after taking the PDE5-inhibitors. Overall, 55% of 137 men who were previously not successful with sildenafil became successful after reeducation and counseling of how to properly take the drug, titration to maximum dose, and a minimum trial of 8 attempts for efficacy assessment [23]. Our patient is asked to repeat his attempts with PDE5-I and wait for longer time before beginning sexual activity. In a follow-up session he reports that he has to wait 2 to 3 hours after using Sildenafil to achieve a good erection. According to our clinical experience screening of personal timing between taking a PDE5-inhibitor to achieving a good result may last between one hour to four hours.

7. Conclusion

Physicians have a major role in addressing sexual problems of their PD patients. Several factors make primary care the ideal setting for discussing sexual issues. First, the longitudinal and personal relationships with patients are assets in discussing and resolving sexual problems; second, the multifactorial issues surrounding SD are appropriately evaluable by the patient's clinician; and third, the long-term follow-up needed to ensure that SD is resolved. Each physician can choose the extent of intervention which corresponds to his capabilities and time constraints. Using the Open Sexual Communication (OSEC) module and short validated questionnaire may assist any physician to promote the sexual quality of life of his PD patients.

Statement of authorship

Conception, design, information acquisition, analysis and completion of article: Gila Bronner.

Conflict of interests

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