

CHAPTER 14

Optimizing Your Love and Sex Life

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THE CHALLENGES PRESENTED BY MS

Although multiple sclerosis (MS) presents challenges, couples can learn to approach things in a head-on, problem-solving fashion and come out on the other side with success. In some cases, your sexual relationship can become even better due to the clarity of your communication.

Even when MS is a part of your relationship, everyone retains the capacity to give and receive pleasure, although, sometimes, creative problem solving is necessary to find satisfying avenues for intimate communication. Understanding how MS symptoms might affect your intimacy and sexuality needs is the first step toward becoming empowered to overcome any obstacles effectively. Whether you are newly diagnosed, physically disabled, young, mature, single, or in a committed relationship, MS does not diminish the universal human need to love and be loved.

THE FREQUENCY OF SEXUAL CHANGES IN MS

In the general population of the United States, the prevalence of sexual concerns or problems ranges from approximately 30 percent for men and up to 40 percent for women. So, it's important to understand that sexual concerns are quite common. Although normal sexual function changes throughout the life span, having MS can affect your sexuality experience in a variety of ways (Laumann and Rosen 1999).

Studies on the prevalence of sexual problems in MS indicate that between 40 to 80 percent of women and 50 to 90 percent of men have sexual complaints or concerns. The most frequently reported

changes in men are diminished capacity to obtain or maintain an erection and difficulty having an orgasm. The most frequent changes that women report are a partial or total loss of libido (sexual desire), vaginal dryness/irritation, and sensory changes in the genitals (Zorzon et al. 1999).

Sexual changes in MS can be characterized as primary, secondary, or tertiary in nature. *Primary sexual dysfunction* stems from neurological changes that directly impair your sexual response and/or sexual feelings. Primary disturbances can include partial or total loss of libido, unpleasant or decreased sensations in the genitals, decreased vaginal lubrication or erectile capacity, and decreased frequency and/or intensity of orgasm. *Secondary sexual dysfunction* refers to MS-related physical changes that indirectly affect your sexual response. Bladder and/or bowel dysfunction, fatigue, spasticity, muscle weakness, problems with attention and concentration, hand tremors, and nongenital changes in sensation are included as the most common MS symptoms that can cause secondary sexual dysfunction. *Tertiary sexual dysfunction* results from psychosocial and cultural issues that can interfere with sexual feelings and sexual response. Depression, changes in family roles, lowered self-esteem, and internalized beliefs and expectations about what defines a “sexual man” or a “sexual woman,” in the context of having a disability, all may contribute to tertiary sexual dysfunction.

THE CENTRAL NERVOUS SYSTEM AND SEXUAL RESPONSE

Sexual response is mediated by the central nervous system: the brain and spinal cord. There is no single sexual center in the central nervous system. Many different areas of the brain are involved in various aspects of sexual functioning, including sex drive, perception of sexual stimuli and pleasure, movement, sensation, cognition, and attention. Sexual messages are communicated between various sections of the brain, thoracic (upper), lumbar (middle), and sacral (lower) spinal cord, and genitals throughout the sexual response cycle. Since MS can result in randomly distributed lesions along many of these pathways, it is not surprising that changes in sexual function are reported so frequently. The good news is that there are likely to be neurological pathways that mediate aspects of sexual feelings and response that are not affected by MS lesions because of how widely distributed they are.

Primary, secondary, and tertiary sexual dysfunction in MS can impact each stage in the entire sexual response cycle.

The Excitement Phase of Sexual Response and MS

MS can interfere with the “excitement” phase of the sexual response cycle at primary, secondary, and tertiary levels. Lesions in the brain can interfere with the interpretation of sexual stimuli as arousing, while lesions of the spinal cord can interfere in the transmission of sexually arousing nerve signals to the genitals. Lesions in the sacral (lower) spinal cord can also cause primary sexual dysfunction, by inhibiting or preventing the inflow of blood to the sex organs, resulting in diminished or absent erections, the lack of clitoral swelling, and/or the absence of vaginal lubrication.

Fatigue can cause secondary “excitement” dysfunction by interrupting the usual capacity to interpret sexual stimuli (e.g., the sight or touch of one’s sexual partner) as exciting, and by decreasing the frequency of sexual thoughts and fantasies.

Another secondary or indirect physical symptom is caused by using medications that may have an impact on your sexual response. For example, some tricyclic antidepressant medications may cause vaginal dryness, and the use of selective serotonin reuptake inhibitors (SSRIs) can cause loss of libido or difficulty having an orgasm.

Changes in role function can cause tertiary difficulties within the “excitement” phase in a number of ways. For example, if you have MS, it may be difficult to see yourself as a fully expressive sexual person, or if your sexual partner is also your primary caregiver, it may be difficult to switch from your caregiver–care receiver to sexual lover roles. This can result in loss of libido (desire). Libido sets the stage for your interpretation of potentially exciting sexual stimuli as exciting.

In addition, negative body image, depression, and feelings of dependency that may result from role changes can all negatively impact the excitement phase by interfering with your psychological processes that are necessary to feel sexually responsive.

The Plateau Phase of the Sexual Response Cycle and MS

In primary sexual dysfunction, MS lesions in the spinal cord may directly make it difficult to sustain penile and clitoral/vaginal engorgement during the plateau phase. In addition, sensory changes in the genitals can interrupt or diminish nerve signals that initiate and/or maintain vasocongestion at both the spinal cord and cerebral cortex (brain) levels. Secondary sexual dysfunction impacts the plateau phase as well. Spastic or *flaccid* (not firm) lower limbs can disturb the increase in lower body muscle tension that normally helps to build excitement during the plateau phase.

Bladder and bowel dysfunction are correlated with reports of sexual problems in MS. Nerve pathways that control the muscles of the bladder are very close to those that regulate the sexual response, and demyelinating lesions in the spinal cord and brain may affect bladder and sexual function together. In tertiary sexual dysfunction, the fear of losing bladder or bowel control during sexual activity with a partner can dramatically inhibit your sexual desire and enjoyment.

Difficulties with attention and concentration may also interfere with the plateau phase of sexual response. Sexual arousal can be sustained only with the continuous interpretation of sexual stimuli as sexually stimulating. Although subtle, impairments in attention can cause you to lose focus during the sexual experience, which can interfere with maintaining arousal. This can be frustrating for both you and your sexual partner; you can have trouble concentrating and this symptom may be interpreted by your partner as meaning that he or she is deficient as a lover.

Orgasm and MS

If you have MS, you may also report loss of orgasm as a symptom, even when the sexual experiences associated with the excitement and plateau phases seem relatively unaffected. More commonly reported are less frequent orgasms, which can result from direct physical (primary), indirect physical (secondary), or the psychosocial (tertiary) causes. In addition, when there are problems interrupting the excitement and plateau phases, the necessary physical and emotional prerequisites for orgasm may be absent.

OPTIMIZING YOUR SEX LIFE: ASSESSMENT OF SEXUAL PROBLEMS

Before you decide to discuss your sexual problems with your healthcare team, take the following test, which was developed specifically for people with MS:

WORKSHEET 30: MS SYMPTOMS AND SEXUALITY*				
Over the last six months, the following MS symptoms have interfered with my sexual activity or satisfaction:	Never 0	Rarely 1	Sometimes 2	Frequently 3
Muscle tightness or spasms in my arms, legs, or body				
Bladder or urinary symptoms				
Bowel symptoms				
Feelings of dependency because of MS				
Pain, burning, or discomfort in my body				
Feeling that my body is less attractive				
Problems moving my body the way I want to during sexual activity				
Feeling less masculine or feminine due to MS				
Problems with concentration, memory, or thinking				
Less feeling or numbness in my genitals				
Fear of being rejected sexually because of MS				
Worries about sexually satisfying my partner				
Feeling less confident about my sexuality due to MS				
Lack of sexual interest or desire				
Less intense or pleasurable orgasms or climaxes				
Takes too long to orgasm or climax				
Inadequate vaginal wetness or lubrication (women)/difficulty getting or keeping a satisfactory erection (men)				
Scoring: Add the Columns =				
Total Score _____				
If you scored 3 on any item, or your total score adds up to more than 6, then you should discuss your sexual issues with your MS healthcare provider.				
* Note: Adapted from Sanders, A. S., F. W. Foley, N. G. LaRocca, and V. Zemon. 2000. The multiple sclerosis intimacy and sexuality questionnaire-19 [MSISQ=19]. <i>Sexuality and Disability</i> 18(1):3–26.				

Your answers to the questions above will give you a place to start. Begin by discussing these issues with your partner and bring your answers to this quiz with you to your MS healthcare provider. The path to finding solutions begins by identifying what the main symptoms or problems are.

FINDING SOLUTIONS FOR CHANGES IN SEXUALITY

Unfortunately, healthcare providers rarely bring up the subject of sexuality, because of patients' personal discomfort, lack of professional training in this area on the healthcare provider's part, or fears of being overly intrusive. However, if you bring up the subject, most providers will be willing to discuss it.

Communicate Proactively with Your HealthCare Providers and Your Partner

It is critical to discuss the changes in your sexual feelings and ask directly about treatments that are available to enhance sexuality. Talk over with your doctor the ways in which your symptoms and the medications used to treat them may be affecting your sexual responses. If you have a sexual partner, bring your partner with you to the appointment, so you can begin the problem-solving process together. To become more comfortable with talking to your partner about these sensitive issues, you can use the checklist below. Which of the following activities are you doing?

Checklist 13: Becoming Comfortable with Your Sexuality

- Agree on when and where to talk about it; if there is a great deal of discomfort, have a professional counselor help you.
- Strive to understand and empathize with each other. This means avoiding blaming, accusing, or expressing your dissatisfactions with each other.
- Focus on clarity between the two of you for concerns about specific areas of sensation and loss, times of tiredness in the day, and other physical or cognitive concerns.
- Take time to touch and hug each other warmly during these discussions.
- Focus only on sharing information and developing the "next steps" in a plan to improve your intimate and sexual communication.
- Do not expect perfection. Above all else, do not forget to support each other throughout this process.
- Remember that MS symptoms may wax and wane. Solutions that work today may need to be revised tomorrow.

Optimizing Libido

If you are in an intimate relationship, begin by focusing on the “sensual” and “special person” aspects of your relationship. Sensual aspects include all forms of physically and emotionally pleasing nongenital contacts like back rubs and gentle stroking of nongenital body zones. During periods of diminished sex drive, you may forget to express appreciation for each other, which is one of the cornerstones of a long-term intimate relationship. The sensual, nonsexual aspects to your physical relationship can become diminished during such periods of diminished sex drive, but they are essential to maintaining emotional intimacy. To counter that possibility, make dates for nonsexual but sensual evenings. You can enjoy each other emotionally and physically and engage in enjoyable sensual exploration of each others’ bodies, without the pressure of working toward sexual intercourse. Tender-hearted, simple cuddling can be delightful and very satisfying. Restore the “special person” aspects to your relationship, which include all those behaviors that demonstrate to your partner that he or she is important and very special to you. Loving gestures tend to get lost in the midst of the pressures of coping with MS symptoms and other life-survival tasks. Increasing these special acts of caring toward one another sets the stage for increasing intimacy which, in turn, sometimes stimulates new libidinous energies.

Whether you currently have a sexual partner or not, exploring your sensual and erotic body zones can be an important step in restoring diminished libido. Combining enjoyable cerebral sexual stimulation (achieved via fantasy, sexually explicit videos, books, and so forth) with masturbation or sensual physical self-exploration is sometimes helpful. Using vibrators or other sexual toys may complement these efforts.

Developing a “sensory body map” with your partner to explore the exact locations of pleasant, decreased, or altered sensations can improve intimate communication and set the stage for increasing pleasure for the two of you.

Sensory Body Mapping Exercise

- Conduct this exercise without your clothes on, in a place that is private, relaxing, and kept at a comfortable temperature.
- Begin by systematically touching your body from head to toe (or all those places you can reach comfortably).
- Vary the rate, rhythm, and pressure of your touch, allowing approximately fifteen to twenty minutes for the entire exercise.
- Note areas of sensual pleasure, discomfort, or sensory change. Alter your pattern of touch to maximize the pleasure you feel (without trying to obtain sexual satisfaction or orgasm).
- Next, inform your partner of your “body map” information and instruct him/her in touching you in a similar fashion.
- Have your partner provide the same information for you (about her/his body map). Take turns giving pleasure to each other, without engaging in sexual intercourse or trying to orgasm. Remember, the emphasis here is on communication and pleasure, not on sex or orgasm. This exercise can set the stage for you to rediscover pleasure in spite of the diminished desire caused by MS.

For women, pelvic floor (or Kegel) exercises sometimes can enhance female sexual responsiveness, although it is not known whether or not they are helpful in MS. To perform the Kegel exercises, alternately tighten and release the pubococcygeus muscle (identifiable as the muscle that starts and stops the flow of urine mid-stream). Exercising this muscle twenty-five or more times a day is recommended.

Note: Initially, it is essential to learn exactly where these muscles are located during urination. But once you know where the muscles are, it is very important to then conduct the exercise when you are *not* urinating. This is important due to the high frequency of urine retention in MS, which can lead to bladder infections.

Optimizing Sexual Pleasure with Decreased or Changed Genital Sensations

To enhance sexual response when decreased or changed genital sensations have occurred, increase stimulation to other erogenous zones, such as breasts, buttocks, ears, and lips. Conduct a sensory “body map” exercise by yourself or with your partner to explore the exact locations of pleasant, decreased, or altered sensations. Increase cerebral stimulation by watching sexually oriented videos, exploring fantasies, and introducing new kinds of sexual play into your sexual activities. As with the treatment of all sexual symptoms in MS, sexual experimentation and communication are the keys to maximizing sexual response and sexual pleasure.

Increase genital stimulation through vigorous oral stimulation or with the aid of mechanical vibrators (available by mail order). Strap-on clitoral vibrators do not interfere with intercourse and require little manipulation once in place. Vibrators that attach to the base of the penis can help to stimulate erections in men, and provide direct clitoral stimulation during intercourse.

Note that painful or irritating genital or body sensations sometimes can be treated with medications. Amitriptyline (Elavil®), carbamazepine (Tegretol®), and phenytoin (Dilantin®) are occasionally prescribed to help manage this difficult symptom.

Optimizing Erectile Function

There are a wide variety of approaches that improve erectile capacity, allowing almost all men to optimize the quality of their erections. Approaches include the following: oral medicines, injectable medicines, intraurethral and topical medicines, mechanical erectile aids, surgery, and counseling.

Medicines. Oral medicines include PDE-5 (phosphodiesterase-type-5) inhibitors. PDE-5 inhibitors work by blocking a chemical in erectile tissue that causes erections to become flaccid. These medicines include sildenafil (Viagra®), vardenafil (Levitra®), and tadalafil (Cialis®). To date, only sildenafil has been completed in its clinical trials with men who have MS, although the other medicines are highly similar and can be prescribed for people with MS. These medicines are helpful in maintaining erections, but they are not useful when the individual cannot initiate an erectile response. Typically, they are taken an hour before anticipated sexual activity. The effects of vardenafil and tadalafil are reported to last somewhat longer than sildenafil, although they have not yet been tested in men who have MS. **Caution:** These medicines cannot be used with some nitrate-based cardiac medicines, since they interact with each other and can lower blood pressure excessively.

In addition to the PDE-5 inhibitors, there are other oral medicines currently in development for erectile dysfunction that work by enhancing or blocking chemical pathways in the brain and spinal cord related to sexual function. To date, none of these medicines have been tried for individuals with MS.

Another approach involves the injection of medications into the penis, such as alprostadil (Prostin VR®) or papaverine, which cause engorgement of the penile erectile tissues. Auto-injectors are available that work with a simple push-button mechanism. The injection usually causes only mild momentary discomfort. Side effects are minimal for most users, if instructions by the urologist or prescribing physician are carefully followed.

Alprostadil can also be administered via urethral suppository (MUSE®), in addition to the penile injection. In this approach, a small plastic applicator inserts the drug into the urethra, where it is absorbed and subsequently stimulates a satisfactory erection in most men. Approximately one-third of men who have tried the drug reported some penile discomfort with its use and in rare instances *priapism* can occur (priapism is a prolonged erection that may require medical care after three hours) (Padma et al. 1997).

Mechanical aids. These are generally noninvasive and include vibrators or vacuum pumps to enhance erections. With a vacuum tube and constriction band, a plastic tube is fitted over the flaccid penis and a suction pump or tube is operated to create a vacuum to produce an erection. A latex band is slipped from the base of the tube onto the base of the penis. The band maintains engorgement of the penis for sexual activities. **Note:** The band cannot be used for more than thirty minutes. If you can attain erections easily, but have difficulty maintaining them, the constriction band alone can be used with satisfactory results.

Mail-order aids. There are a number of sexual aids available by mail order that do not require a physician's prescription. Some men prefer strap-on latex penises, some of which are hollow and can hold a flaccid or semi-erect penis. Strap-on, battery-operated vibrators in the shape of a penis are also available.

Prostheses. A more invasive form of treatment for erectile problems is the penile prosthesis. Although there are different types of prostheses, they all require surgical insertion of rods or inflatable chambers into the penis. There are greater risks associated with surgery than with other methods, such as infection, scarring, and other difficulties with the implants. Nevertheless, approximately 80 percent of men using these types of prostheses find them satisfactory. In general, a penile prosthesis is recommended only when other efforts to manage erectile dysfunction have not been successful (Brinkman et al. 2005).

Counseling. Finally, counseling is very helpful, particularly when there is performance anxiety, depression, inhibition about communication, or other tertiary sexual problems. When coping with erectile dysfunction, it is very important to include your sex partner in the discussion, if you are in a long-term relationship. This will enhance intimacy by allowing both of you to learn and explore together. If partners feel inhibited about talking through these issues, counseling with a mental health professional who is knowledgeable about MS can be helpful.

Optimizing Pleasure When Vaginal Dryness or Tightness Occurs

Similar to the erectile response in men, the vaginal lubrication response in women is controlled by multiple pathways in the brain and spinal cord. *Psychogenic lubrication* originates in the brain, and occurs through fantasy or exposure to sexually related stimuli. Establishing a relaxing, romantic, and sexually stimulating setting for sexual activity, incorporating relaxing massage into foreplay activities, and prolonging such foreplay activities can enhance psychogenic lubrication.

Reflexogenic lubrication occurs through direct stimulation of the genitals via a reflex response in the sacral (lower) part of the spinal cord. Reflexogenic lubrication sometimes can be increased by manually or orally stimulating the genitals. The simplest method to cope with vaginal dryness is to apply generous amounts of water-soluble lubricants (e.g., K-Y® jelly). Make sure you use plenty of lubricant . . . most people do not use sufficient amounts. Don't be afraid to "soak the sheets." Some women report that using vegetable oils such as corn oil (typically used for cooking) feels more soothing on vaginal tissues than water-based lubricants. Healthcare professionals do *not* advise the use of petroleum-based jellies (e.g., Vaseline®) for vaginal lubrication, because they can leave residues that could cause bacterial infections to develop.

Optimizing Pleasure When Spasticity Occurs

Spasticity in the hips or legs can make finding a comfortable position for sexual intercourse very difficult. Active management of symptoms typically includes physical therapy exercises and antispasticity medications. Administering antispasticity medication before engaging in sexual activity can be helpful. Be sure, however, to discuss any medication changes with your physician.

Another approach for coping with spasticity is to explore alternative sexual positions for intercourse. Women with spasticity of their adductor muscles may find lying on their side with the partner approaching from behind more comfortable. A man who has difficulty straightening his legs may find that sitting upright in an armless chair allows his partner to mount his erect penis. However, everyone's body is different, and the key to finding alternative sexual positions is open exploration and communication between partners.

Note: It can be very helpful to try new positions while you still have your clothes on (i.e., when you are not engaging in sexual acts), so that any anxiety you or your partner feels will be reduced and you both will not feel so vulnerable.

Optimizing Sexuality with MS-Related Fatigue

Typically, fatigue is managed from physical therapy, occupational therapy, and pharmacological perspectives. Consult your MS healthcare team about potential medicines for fatigue. Having sex in the morning or at times during the day when your energy levels are higher can compensate for fatigue. If you're tired, be honest, and you can make a date after you take a nap or for a different time of day. In addition, exploring sexual positions that minimize weight-bearing or tiring movements can minimize fatigue. Open communication and the willingness to engage in trial-and-error exploration are essential ingredients.

Optimizing Sexuality with Bladder Dysfunction

Tailoring symptomatic bladder management strategies around anticipated sexual activity is the basic approach. Proactive discussion with your sex partner and MS healthcare team minimizes the risk of incontinence during sexual activity. For example, altering your schedule for taking anticholinergic medications (frequently given for bladder storage dysfunction) to thirty minutes before anticipated sexual activity may minimize bladder contractions during sex. Because vaginal dryness increases with the use of

these medicines, using water-soluble lubricants is important. Restricting your fluid intake for an hour before sex and conducting intermittent catheterization just before engaging in genital sexual activity will also minimize incontinence. Men who experience small amounts of urine leakage can wear a condom during sex.

Women who have indwelling catheters can tape the catheter securely to the stomach, empty the collecting bag before sexual activity, and put additional tape around the top ring to minimize the chances of leaks. Lying in a “nestled spoons” position with the woman in front, and using rear entry intercourse, will avoid putting pressure on the catheter or the collecting bag.

Optimizing Sexual Function with Muscle Weakness

Finding new positions for satisfactory sexual activities can compensate for weakness. Reclining positions are less tiring, pillows under the hips can improve positioning and reduce muscle strain. Oral sex requires less movement than intercourse, and using hand-held or strap-on vibrators can provide sexual satisfaction while compensating for muscle weakness. If both partners conduct a “positioning” exercise before sex, that will help them to determine whether the new positions are comfortable, without introducing anxiety during sexual activity.

Optimizing Your Sex Life When Changes in Attention and Concentration Occur

Changes in attention and concentration may derail your ability to sustain sexual interest, which may create feelings of confusion, guilt, and rejection. These negative feelings can increase distractibility, or lead you to avoid sex altogether. In general, minimizing nonromantic or nonsexual stimuli and maximizing sensual and sexual stimulation during sex is the best strategy for compensating.

Use multisensory stimulation, including talking in sexy ways, sensual and erotic touching, and playing romantic music can help to minimize this problem. When the partner with MS loses focus, briefly switching from erotic to nonerotic touching can create an atmosphere of acceptance and ease the couple back into erotic sexuality.

Sometimes, body image concerns can prove distracting, since you may tend to concentrate or focus on areas of your body or your partner’s (or performance) that you’re not satisfied with, rather than the pleasure you are capable of giving or receiving. If you find your thoughts drifting away from the pleasure of the moment and onto body image or other concerns, it’s very important to redirect your attention back to those aspects of your body you are pleased with, or back to appreciating what you can enjoy.

Optimizing Sexuality with Depression or Other Changes in Mood

Frequently, MS is associated with clinical depression, grief, demoralization, or temporary changes in self-esteem and body image. These emotional challenges can temporarily dampen sexual interest and pleasure, especially clinical depression. Usually, medications and psychotherapy can offer relief from clinical depression, which restores sexual interest. However, a group of antidepressants called selective serotonin reuptake inhibitors (SSRIs), which include Prozac®, Paxil®, Zoloft®, and Lexipro®, can cause

loss of libido or interfere with orgasm. **Note:** Before you begin any antidepressant therapy, consult your doctor about any potential sexual side effects.

Coping with Role Changes and Loss of Intimacy

Western cultural expectations about sex include the notion that sex should be spontaneous and passionate. If enculturated visions of what sex “should be” are not met, lovers may feel so disappointed that they withdraw from the sexual relationship and fail to explore or enjoy other sexual possibilities.

In Western societies, women are particularly susceptible to having a negative body image, which MS-related disabilities may exacerbate. Similarly, men with MS may view themselves as failing to live up to some internalized role such as “breadwinner,” being physically strong and brave, or being the sexual initiator. Sometimes, the struggle with internalized role expectations for yourself and your partner can result in a gradual loss of seeing each other as sexually appealing.

This process can become accelerated if the “well” partner provides extensive care and assistance to the “sick” or “disabled” partner. When caregiving becomes an extensive part of a relationship, it can be difficult to relax and have sexual fun. See chapter 12 on the care partner relationship for the importance of respite for the caregiver and the importance of using many other resources for caregiving needs. A diminishing capacity to understand and work through these issues also can create greater isolation and misunderstanding, and resentments toward each other may grow (see chapter 10 for further clarification of cognitive concerns).

Obtaining educational and resource materials can facilitate helpful discussions. They are available through the National Multiple Sclerosis Society or from other resources listed at the back of this book. In addition, there are many self-help books available at most local bookstores that are designed to enhance sexual and intimate communication. Read them with your partner. Set aside time each week to talk about what you are reading, and decide whether what you’ve read applies to your relationship or not.

Another approach involves setting aside time each week or making actual dates, on a regular basis, to devote the time exclusively to restoring intimacy and talking about your sexuality. This can set the stage for a couple to slowly develop greater ease in talking about their sensual, sexual, and intimate desires and differences. The MS situation requires that couples “rediscover” each other, because their roles and expectations need to be updated or reconciled with the presence of MS.

Conclusion

This chapter is not meant to be exhaustive in relation to examining concerns that can affect your sexuality with MS. It is also not exhaustive in relation to strategies for improving your love and sex life, e.g., the impact of any of your medications could be important. Nevertheless, it is hoped that this chapter will provide you with a good framework for overcoming the challenges that MS may have brought into your sexual life.