SEXUAL ISSUES IN SCI WOMEN

Michal Lew-Starowicz MD, PhD, FECSM
Assoc.Prof. at III Department of Psychiatry
INSTITUTE OF PSYCHIATRY AND NEUROLOGY
WARSAW, POLAND
Principal/Sub-Investigator, Consultant or Lecturer for the following companies:

- Bayer
- Bristol Myers Squibb
- Eli Lilly
- Johnson & Johnson
- Pfizer
- Plethora
- Polpharma
- Servier
- Verco

Conflict of interests according to this lecture: none
SEXUAL ISSUES IN SCI WOMEN

OBJECTIVES

1. How sexual experiences/expectations change in women after SCI?
2. Sexual adjustment & gender differences
3. What factors are important to preserve/enhance sexual life after SCI?
4. Treatment approach for SCI women
CHAPTER 16.5. SPINAL CORD INJURY
(Marca L Sipski, Craig J Alexander)

“Our understanding of the impact of spinal cord injury on female sexual response and sexuality is probably greater than that of any other physical problem. Despite this fact, our understanding of and ability to document the presence of sexual dysfunction in women with spinal cord injury remain in their infancy. Moreover, our ability to treat sexual dysfunction in this population remains unproven.”
THE 2 KINDS OF SOCIAL STIGMA ABOUT SCI PEOPLE

1. Negative:
   • Depressed, miserable, hopeless
   • They don’t have sexual needs/desire, can’t have sex/orgasm
   • They can’t/shouldn’t have children/get married

2. Extraordinary:
   • Inspirational icon, “happy despite…”, overcoming limitations

So…
Where are regular people?
- Same needs, expectations regarding love, intimacy, sex life, children etc. !!!
"HOW MUCH DO THEY CARE ABOUT SEX?"
HEALTH AND LIFE PRIORITIES IN SCI PATIENTS

- A systematic review (Medline, CINHAL, EMBASE, PsycINFO) on studies from 1948 to Apr 2011
- 656 articles → 24 met Incl. Crit.
- 5262 pts (17-98y), time since SCI <1-52 y.
- 7/11 articles on health priorities included sexual issues
- Areas of greatest priority:

### Health priority studies

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Functions ranked in the top 25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson 2004</td>
<td>681</td>
<td>Tetraplegia: (1) arm/hand function (2) bowel/bladder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paraplegia: (1) sexual function (2) bladder/bowel/AD</td>
</tr>
<tr>
<td>Anderson et al. 2009</td>
<td>137</td>
<td>(1) dressing (2) feeding oneself</td>
</tr>
<tr>
<td>Bloemen-Vranken et al. 2005</td>
<td>454</td>
<td>(1) bladder (2) bowel (3) pain (4) spasms (5) sexuality (6) pressure sore</td>
</tr>
<tr>
<td>Brown-Friolo et al. 2002</td>
<td>94</td>
<td>(1) walking</td>
</tr>
<tr>
<td>Ditzmo et al. 2008</td>
<td>31</td>
<td>(1) bowel/bladder (2) walking (3) toileting (4) bathing</td>
</tr>
<tr>
<td>Henson &amp; Franklin 1976</td>
<td>128</td>
<td>Tetraplegia: (1) arm/hands (2) bowel/bladder (3) use of legs (4) sexual function</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paraplegia: (1) use of legs (3) bowel/bladder (3) sexual function</td>
</tr>
<tr>
<td>Kimmistö et al. 1998</td>
<td>65</td>
<td>Recent injury: (1) mental function (2) breathing (3) moving (4) seeing (5) communicate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Long standing injury: (1) mental function (2) breathing (3) communicate (4) moving</td>
</tr>
<tr>
<td>Lannin &amp; Lankhoorn 1994</td>
<td>25</td>
<td>All 35 items were rated important</td>
</tr>
<tr>
<td>Snoek et al. 2004</td>
<td>1475</td>
<td>Tetraplegia: (1) hand (1) bowel (1) bladder (2) sexual function</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paraplegia: (1) bladder (1) bowel (2) pressure sore</td>
</tr>
<tr>
<td>Snoek et al. 2005</td>
<td>47</td>
<td>UE function, bowel/bladder sexual function, standing/walking received same preference weights</td>
</tr>
<tr>
<td>Wagner et al. 2007</td>
<td>50</td>
<td>(1) UE function</td>
</tr>
</tbody>
</table>

Simpson et al., J Neurotrauma 2012; 29(8): 1548-55
BACKGROUND CONSIDERATIONS

SEXUAL FUNCTION

EROTICISM

HUMAN SEXUALITY
CULTURAL BACKGROUND
- Where is the sexuality of SCI women?

Women with disabilities receive sexual information more seldom than men (Nosek et al., 1996)
Multicenter - spinal cord centres in Sweden, Denmark, Norway, Finland and Iceland
SCI women 18-65y (n=545, 57% r.r.) and control group (n=507, 51% r.r.)
Questionnaire-based (104-item Spinal Cord Injury Women Questionnaire)
Neurological classification:
Tetraplegia:
  complete (T.C.) 12%, incomplete (T.I.) 23%
Paraplegia:
  complete (P.C.) 25%, incomplete (P.I.) 40%
WORSE OR DIFFERENT?
sexual outcomes in SCI women (1)

• Sexual interest after SCI...
  • **Decreased desire**
    (Bregman & Hadley, 1976; Kreuter et al., 2008; Sipski et al., 1993, 1995).
  • **Sexual activity less important** especially in tetraplegic & complete lesions
    (Charlifue et al., 1992; Kreuter et al., 2008)
  • **Decrease in frequency of masturbation** (Sipski, 1997)
  But...
  • **80% engaged in sexual activity** with partner (± intercourse) after SCI (Kreuter et al., 2008)
  • **Sexual activity increases with time** after SCI but depends on the severity of the injury
    (Kreuter et al., 1996, 2008; Jackson & Wadley, 1999; Fisher et al., 2002)
WORSE OR DIFFERENT?
sexual outcomes in sci women (2)

- **Women are more likely to preserve orgasm** after SCI than men (Alexander & Rosen, 2008)

- 52% of all (n=25) women with SCI ≥T6 achieved orgasm in laboratory setting, unrelated to level/completeness of injury (Sipski et al., 1995)

- **Increased orgasm latency** (Sipski et al., 2001)

- Predictors of sexual satisfaction change after SCI
  
  - **Non-intercourse sexual intimacy preferred** – kissing, hugging, touching (Charlfue et al., 1992)
  
  - **Increased impact of relationship quality, intimacy and partner satisfaction** on sexual satisfaction
    
    (Anderson et al., 2007; Burns et al., 2001; Kreuter, 2000; Nosek et al., 1996; Reitz et al., 2004; Siosteen et al., 1990)
Let’s talk about sex...

- Difficult study group
- „The hospital shock effect”
- Caregiver vs care-receiver
- Body appearance issues
- Dating issues
- Trust issues
- Validated tools vs patients’ narratives
Conceptualizations of sexuality based on SCI women narratives

6 SEXUAL DOMAINS:
1. Self versus other focus
2. Genital versus whole-body focus
3. Physical sexual versus holistic intimacy
4. Bodily versus mental phenomenon
5. Exuberance versus negativity continuum
6. Past versus present orientation

Leibowitz and Stanton, Rehabilitation Psychology 2007, 52(1): 44-55
Sexuality definitely means something to me different than it did before my accident. . . . Now I think that it means not only a sexual act, but it actually means the feelings you have, the thoughts you have, and how you express yourself . . . In a nutshell, how you see yourself as a person . . . how you feel about yourself. . . . It’s a whole lot more mental than I ever thought it was . . . and I think that’s just a lesson I had to learn, which was good for me.

Angel

Leibowitz and Stanton, Rehabilitation Psychology 2007, 52(1): 44-55
PSYCHOSOCIAL & SEXUAL ADJUSTMENT

GENDER DIFFERENCES
(Kirenko & Lew-Starowicz, 2001)

SCI women (n=25) vs SCI men (n=64): (p<0.05)
• Less dysharmonic in sexual response
• Less pressure on sexual function
• Lower self-esteem as sexual partner
• Less sexual pleasure
• Greater impact of psychosocial adjustment on sexual functioning
SCI WOMEN WHO REMAIN SEXUALLY ACTIVE –
2 COMMON TYPES OF SEXUAL ADJUSTMENT:
canonical correlation (Kirenko & Lew-Starowicz, 2001)

- **Pragmatic** (p=0.002)
  - More realistic and critical about life and their general functioning
  - Positive assessment of relationship with partner
  - Less dissatisfied in their sexual activity, more sexual desire
  - Don’t like partner being more active in sexual activity (self-esteem)

- **Striving for self-affirmation** (p=0.072)
  - Avoiding confrontation with difficulties
  - Less competent in stress reduction
  - Stronger attachment to relatives and partners
  - Lower sexual self-esteem, less sexual desire, allow partner being more active
PRIORITY 1: OVERCOMING MENTAL OBSTACLES

- Changes in sexual self-confidence
  - Feeling very or rather attractive: 74% before and 41% after SCI vs 62% in control group (p<0.001)
  - Feeling not at all attractive: 37% with complete vs 21% with incomplete injury (p=0.01)
  - Being able to please a partner sexually: 93% before SCI and 91% controls vs 66% after SCI (p<0.001)

- Decreased sexual activity because of
  - lack of spontaneity (25%)
  - body shame (17%)
  - fear of falling (17%)
  - lack of self-confidence (15%)

Table III. Reasons listed for being single (more than one reason could be given)

<table>
<thead>
<tr>
<th>Reason</th>
<th>SCI</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=102</td>
<td>n=82</td>
</tr>
<tr>
<td>Have not met the “right” partner yet</td>
<td>55 (54)</td>
<td>70 (85)</td>
</tr>
<tr>
<td>Low self-esteem</td>
<td>36 (35)</td>
<td>16 (20)</td>
</tr>
<tr>
<td>Feelings of being unattractive</td>
<td>39 (38)</td>
<td>9 (11)</td>
</tr>
<tr>
<td>Fewer opportunities to make new contacts</td>
<td>49 (48)</td>
<td>28 (34)</td>
</tr>
<tr>
<td>Doubts about sexual ability</td>
<td>34 (33)</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Decreased sexual interest</td>
<td>14 (14)</td>
<td>6 (7)</td>
</tr>
<tr>
<td>Fear of bladder and/or bowel leakage</td>
<td>32 (31)</td>
<td>0</td>
</tr>
<tr>
<td>Feelings of being inadequate when confined to wheelchair or having a visible disability</td>
<td>54 (53)</td>
<td>–</td>
</tr>
<tr>
<td>Feelings of inadequacy</td>
<td>–</td>
<td>11 (13)</td>
</tr>
<tr>
<td>Lack of time</td>
<td>6 (6)</td>
<td>15 (18)</td>
</tr>
</tbody>
</table>

Kreuter et al., J Rehabil Med. 2008; 40: 61-69
PRIORITY 2: BEING IN THE RIGHT MOOD

• Very important for **willing to have sex** for 30% before vs 48% after the injury (p<0.01)

• To be able to **experience pleasure** during sexual activity: 30% before vs 56% after the injury (p<0.01)

[Kreuter et al., 2008]

• **Depression** rate 10-41% in SCI women, highly underdiagnosed

(Calpakjian & Albright, 2006; Robinson-Whelen et al., 2014; Williamson & Elliott, 2013)

• If treated – look for **AD’s side effects**
PRIORITY 3: OVERCOMING PHYSICAL OBSTACLES

- Main „Physical“ reasons for not engaging/engaging less often in sexual activity:
  - Sensory loss/decreased sensation
  - Pain
  - Decreased mobility
  - Problems with positioning
  - Bladder & bowel leakage

(Kreuter et al., 2008; Westgren et al., 1997)
PRIORITY 4: RELATIONSHIP SATISFACTION

• Stable partner in 76%, relationship assessed as good/very good in 63-85%
  But

• 33% - 67% experience separation after SCI and 28% - 50% report the separation was caused by the injury (Kreuter et al., 2008)
BARRIERS IN IMPLEMENTING SEXUAL HEALTH ISSUES INTO REHABILITATION

• Sexual health often overlooked due to (Hartshorn, 2013)
  • Personal discomfort with the topic
  • Cultural barriers
  • Moral convictions
  • Sexual myths
  • Sexual inadequacies
  • Lack of sufficient knowledge to provide education

• Pretexts for noninvolvement in sexual education particularly prevalent when dealing with disabilities? (Booth et al., 2003)
• We see a person now…

• Who was she before?

- SCI injury
- Changes in sensory & motor functions, self-image, assigned meanings
- Personality remain initially the same but may change in time
- Positive or negative self-integration
APPROACH (1): EDUCATION

- Highly needed from patients’ perspective
  (Fisher et al., 2001; McAlonan, 1996)
- Tailored to patients’ needs
- Positive association with sexual activity (Hess & Hough, 2012)
- Leaflets
  - Pro-sexual
  - Sensitive for sexual issues in SCI women
  - Giving permission/encouraging to talk with professionals
  - Practical information
APPROACH (2): SEXUAL HEALTH TEAM

- Adapting the PLISSIT model
- Following relevant education, the proportion of nurses willing to be involved in sexual health rehabilitation at more complex levels raised from 66% to 90%

APPROACH (3): CLINICAL ASSESSMENT

**Function preservation**
- Pinprick/touch/vibration/pain sensation in the T11 – L2 dermatomes
- Rectal contraction/sensation
- Bulbocavernous reflex
- Vaginal pulse amplitude
- Lubrication (reflex?)

**Other physical issues**
- Continence
- Positioning
- Mobility, spasticity
- Medication side effects

**Psychosocial issues**
- Body image
- Self-esteem
- Mood, vitality
- Concerns about disability
- Lifestyle changes
- Relationship issues
## Approach (4):
**Practical Information/Recommendations for Patients According to the Level of Injury**

<table>
<thead>
<tr>
<th>Injury Type</th>
<th>Likely to Experience, Reflexive Arousal: Erection/Vaginal Lubrication</th>
<th>Likely to Experience, Psychogenic Arousal: Erection/Vaginal Lubrication</th>
<th>Orgasm</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete upper motor neuron injury cephalad to T11</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>1. Genital stimulation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Stimulation of sensate erotic body parts</td>
</tr>
<tr>
<td>Complete upper motor neuron injury caudal to T11–L2 with sparing of sacral spinal segments</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>1. Genital stimulation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Stimulation of sensate erotic body parts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Audiovisual, tactile gustatory and imaginative stimuli/fantasy</td>
</tr>
<tr>
<td>Conus injury/lower motor neuron injury (loss of sensation/voluntary control S4–S5, loss of S4–S5 mediated reflexes)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>1. Assisted lubrication (e.g., KY jelly)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Stimulation of sensate erotic body parts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Audiovisual stimulation/fantasy</td>
</tr>
<tr>
<td>Incomplete injuries</td>
<td></td>
<td></td>
<td></td>
<td>Ability to appreciate pin touch sensation in S2, 3, 4 dermatomes correlates with ability to attain psychogenic arousal and achieve ejaculation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ability to perceive T10–L2 dermatomes correlates with the ability to attain psychogenic erection/lubrication, and the better the response to fantasy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Preservation of sacral sensation or voluntary sacral control of S4–5 correlates with ability to attain reflexogenic erection/vaginal lubrication</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Regardless of level or completeness, approximately 50% SCI individuals experience orgasm</td>
</tr>
</tbody>
</table>

Deep vaginal stimulation increases the chance of pleasurable sensation and orgasm in women with SCI at/above T10

- SCI ≥ T10 – elimination of pudendal, pelvic and hypogastric afferents
- Vaginocervical stimulation – a spinal cord-bypass pathway via Vagus nerves (Komisaruk et al., 2004)
- Nucleus Tractus Solitarii (medulla oblongata) response to mechanical stimulation of vagina, cervix, uterus or rectum, altered by vagotomopy (Hubscher & Berkley, 1994, 1995)

Komisaruk et al., Brain Research 1024 (2004), 77-88
PHARMACOLOGICAL/PHYSICAL TREATMENT OPTIONS

Men
- PDE-5 inhibitors
- ICI
- Vacuum constriction devices
- Penile prostheses
- Vibro/electrostimulation
- Midodrine

Women
- Poor evidence on PDE-5-I
- Vibro/electrostimulation


**APPROACH (5): INCREASING STIMULATION MODALITIES**

- **Perineal assessment** – adapting treatment to the post-SCI remaining capacity of the vulva
- **Erotica + masturbation**, gradually adding stimulation modalities
- **Multimodal investigation/stimulation** coaching
  - 85% of SCI women gained better perception with multimodal investigation (esp. vibrostimulation)
  - 79% could reach orgasm with vibrostimulation (Ferticare® device) ± midodrine
    - (Courtois et al., 2011, 2013)
- **Dildos/vibrators + straps** if limited grasp (i.e. Velcro straps) (Krassioukov et al., 2009)
- **Body mapping** (Foley & Werner, 2000)
## Table IV. Sexual expressions listed to be of importance for becoming sexually aroused

<table>
<thead>
<tr>
<th>Preferred type of sensory stimulation for becoming sexually aroused</th>
<th>Before injury</th>
<th>After injury</th>
<th>Before vs after injury</th>
<th>Controls</th>
<th>Before injury vs controls</th>
<th>After injury vs controls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 415</td>
<td>n = 415</td>
<td>p-value</td>
<td>n = 502</td>
<td>p-value</td>
<td>p-value</td>
</tr>
<tr>
<td>Visual</td>
<td>137 (33)</td>
<td>147 (35)</td>
<td>1</td>
<td>131 (26)</td>
<td>0.027</td>
<td>0.0028</td>
</tr>
<tr>
<td>Hearing</td>
<td>65 (16)</td>
<td>88 (21)</td>
<td>0.0021</td>
<td>58 (12)</td>
<td>0.086</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Taste</td>
<td>45 (11)</td>
<td>55 (13)</td>
<td>0.2101</td>
<td>53 (11)</td>
<td>0.97</td>
<td>0.25</td>
</tr>
<tr>
<td>Smell</td>
<td>97 (23)</td>
<td>113 (27)</td>
<td>0.3915</td>
<td>147 (29)</td>
<td>0.052</td>
<td>0.54</td>
</tr>
<tr>
<td>Sexual fantasies</td>
<td>114 (27)</td>
<td>156 (38)</td>
<td>&lt; 0.001</td>
<td>125 (25)</td>
<td>0.42</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Hugging, kisses, caresses</td>
<td>297 (72)</td>
<td>304 (73)</td>
<td>0.7428</td>
<td>372 (74)</td>
<td>0.43</td>
<td>0.83</td>
</tr>
<tr>
<td>Caresses of the breast with hands</td>
<td>198 (48)</td>
<td>220 (53)</td>
<td>0.7035</td>
<td>232 (46)</td>
<td>0.70</td>
<td>0.047</td>
</tr>
<tr>
<td>Caresses of the breast with mouth</td>
<td>192 (46)</td>
<td>209 (50)</td>
<td>1</td>
<td>257 (51)</td>
<td>0.16</td>
<td>0.85</td>
</tr>
<tr>
<td>Caresses of the genitals with hands</td>
<td>226 (54)</td>
<td>171 (41)</td>
<td>&lt; 0.001</td>
<td>307 (61)</td>
<td>0.048</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Caresses of the genitals with mouth</td>
<td>173 (42)</td>
<td>109 (26)</td>
<td>&lt; 0.001</td>
<td>198 (39)</td>
<td>0.53</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Vibrator stimulation of clitoris</td>
<td>38 (9)</td>
<td>37 (9)</td>
<td>0.4050</td>
<td>45 (9)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Vibrator stimulation with artificial penis</td>
<td>26 (6)</td>
<td>30 (7)</td>
<td>1</td>
<td>20 (4)</td>
<td>0.16</td>
<td>0.045</td>
</tr>
<tr>
<td>Stimulation of vagina and clitoris</td>
<td>112 (27)</td>
<td>84 (20)</td>
<td>&lt; 0.001</td>
<td>123 (24)</td>
<td>0.43</td>
<td>0.14</td>
</tr>
<tr>
<td>Sexual intercourse</td>
<td>231 (56)</td>
<td>171 (41)</td>
<td>&lt; 0.001</td>
<td>211 (42)</td>
<td>&lt; 0.001</td>
<td>0.85</td>
</tr>
<tr>
<td>Caressing of body parts at the level of injury</td>
<td>n.a.</td>
<td>41 (10)</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

p-values for Fisher’s exact test.

n.a.: not applicable

Kreuter et al., J Rehabil Med. 2008; 40: 61-69
## APPROACH (6):
DEALING WITH OTHER SYMPTOMS THAT INTERFERE WITH SEXUAL ABILITY

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Dealing strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spasticity, contractures, pain</td>
<td>Stretching, massage, comfortable positioning (with use f.i. pillows, enhancers), pharmacotherapy, neuroablative surgery (Anderson et al., 2007; Hess &amp; Hough, 2012; Parziale et al., 1993; Taricco et al., 2000)</td>
</tr>
<tr>
<td>Incontinence</td>
<td>Timing of bladder and bowel activities, bladder relaxants, indwelling/suprapubic catheter, continent diversion (Consortium of Spinal Cord Medicine, 2006; Hess &amp; Hough, 2012; Moreno et al., 1995)</td>
</tr>
<tr>
<td>Skin irritation, wounds</td>
<td>Skin monitoring, appropriate positioning, hydrocolloid dressing (Hess &amp; Hough, 2012)</td>
</tr>
<tr>
<td>Autonomic dysreflexia</td>
<td>Stop sexual activity, upright position, pharmacotherapy (Consortium for Spinal Cord Medicine, 2002)</td>
</tr>
<tr>
<td>Adjustment disorders and depression</td>
<td>Crisis intervention, environmental support, psychotherapy, antidepressants with less sexual side-effects (Elliott &amp; Frank, 1996; Hess &amp; Hough, 2012)</td>
</tr>
</tbody>
</table>
CONSTRUCTIVIST APPROACH
- looking for a new sexual script

- SCI woman – need to rethink her sexuality
- Partner - left behind or mutual change?
- Open discussion
  - Understanding both perspectives
  - Looking for compromise
- Building new sexual script

Atwood & Dershowitz; Journal of Sex and Marital Therapy 1992, 18: 196–218
CONCLUSIONS: FOCUS ON SEXUAL DISABILITY

- There is no just an „SCI woman”
- They remain (or become) sexual (or sexy)
- Sexual health team needed, early intervention!
- Need for open-dialogue, pro-sexual education
- Long-term facilitation of sexual function but focus on sexual satisfaction
- Involvement of partner in sexual rehabilitation