Sexual Health
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The Birds and Bees of Sexual Health

Sexual health is an important concept that directly and indirectly affects the lives of individuals, couples, and families. Those described as “sexually healthy” are considered to have a physically and emotionally enjoyable sexual life. The World Health Organization (2006) defined sexual health as: “the integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personal, communication and love.”

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Although sexual health affects many areas of one’s life, children and marriage and family therapists (MFTs) may not make sexual health a priority. Some therapists believe they have limited knowledge to discuss concerns related to sexual health. This could be due to the fact that many MFTs do not receive specialized training in sex therapy during the course of their graduate work; likewise, sex therapists are capable of addressing the complex interplay of physical, emotional, intellectual, and social aspects in the promotion of sexual health. For example, MFTs can assist adolescents who have misguided notions regarding contraception, which can directly influence their decision-making regarding sexual health behaviors. MFTs can also help some couples understand the extent to which imbalances in the couple’s power dynamics or fears of intimacy limit their ability to achieve overall sexual health.

There are several approaches/treatment models that are designed to help a couple achieve optimal sexual health. Treating sexual dysfunctions was originally handled from a psychoanalytic perspective, because it was believed that sexual symptomatology was derived from an underlying problem, which required long-term, intensive individual treatment (Wiederman, 1998). As the behavioral models began to take prominence in the late 1960s and early 1970s, treatment for sexual dysfunction followed suit. Kaplan’s (1974) approach is primarily behavioral and in many ways was similar to that of Masters and Johnson (1966), in terms of the individually-oriented thinking that pervaded the Masters and Johnson approach. Kaplan did offer a psychodynamic overlay in her approach and was, therefore, exploring the problems from a depth perspective, similar to that of the early sex therapists. It was often difficult, however, to understand how the psychodynamic perspective added to her behavioral emphasis or created greater change (Kaplan, 1974).

Cognitive behavioral therapies (CBT) have also been utilized in the treatment of sexual problems. McCabe (2001) found that a CBT approach to treatment improves attitudes about sex, believed sex was more enjoyable than prior to treatment, and experienced improvement in the dysfunction. Some elements of the cognitive behavioral approach include communication training (including verbalization of feelings, active versus passive listening, and effectively managing conflict), reducing performance anxiety, and prescribing sensate focus activities (see, for example, McCabe, 2008).

Finally, there are approaches that integrate cognitive, behavioral, psychodynamic, and couple components. The Intersystems Approach is one such approach and incorporates the variety of contexts in which the individual and couple are embedded. Conceptualized as a vulnerability model (e.g., assessing several areas of vulnerability to sexual problems) (see, for example, Trepper & Barrett, 1989) and grounded in the Intersystems Approach developed by Weeks (1994) and outlined in detail by Hertlein et al. (2008), helping couples attain optimal sexual health includes assessment and treatment across five dimensions: individual-psychological, individual-biological, dyadic, family-of-origin, and sociocultural. In this approach, these domains help clients develop and maintain a positive, respectful approach to sex and sexuality. The Intersystems Approach grew out of the early theoretical thinking of Weeks (1977) and was refined over many years. The approach was first applied to sex therapy by Weeks and Hof and later in books by Weeks and Gambescia (2000; 2002). The Intersystems Approach moves beyond technical eclecticism to a comprehensive theory, which can embrace multiple theoretical perspectives. While the approach itself has not been empirically validated, the factors contributing to each component of the theory (i.e., individual biology, individual psychology, etc.) has at least one supporting piece of research (see Hertlein et al., 2008, for specific references). Thus, if you examine the individual, interpersonal, and intergenerational aspects of each system, you will find there is research that supports each component. Logically, it would follow that if a problem is maintained by several factors that are determined during assessment, then the treatment of each of those factors would be essential to recovery or improvement.

Though there are many clinical models, there are few empirically validated approaches to treatment (Heiman & Meston, 1997a). Of the studies reviewed by Heiman and Meston, some reviewed validation, but none had any long-term data and the short-term data showed a high drop-out rate. This is likely due to several reasons:

- The youth of the field of sex therapy (Wiederman, 1998)
- Few certified sex therapists (approximately 444 certified sex therapists in the U.S., per www.aasect.com), most of which are in practice
- Treatment manuals are uncommon (Heiman & Meston, 1997a)
- Lack of control groups (Heiman & Meston, 1997a)
- Limited research funding (Heiman & Meston, 1997a)
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These factors make it virtually impossible to research the effectiveness of sex therapy. As usual, clinical practice runs ahead of the science or empirical validation.

Diagnosis and Assessment
Because sexual health encompasses both physical and emotional well-being, MFTs have a distinct advantage in forming a diagnostic impression from a systemic perspective, including how individual, interpersonal, and contextual dimensions contribute to sexual health concerns. The traditional view of treating sexual problems is individualistic and behavioral, whereas our perspective is clearly systemic, resulting in a comprehensive assessment and treatment experience. The DSM-IV-TR (APA, 2000) based its definition of problematic sexual behavior on the Masters and Johnson (1966) human sexual response cycle. The sexual dysfunctions listed in the DSM-IV-TR are “characterized by a disturbance in the processes that characterize the sexual response cycle or by pain associated with sexual intercourse” (APA, 2000, p. 535). Sexual dysfunctions are classified as being in one of four categories (see Table 1).

One way to identify the extent to which the sexual health problem stems from organic or psychological factors is through using the specifiers as outlined in the DSM-IV-TR (APA, 2000). Sexual dysfunctions identified as “lifelong” are those that the client describes as being under voluntary control. In one case, a wife told her husband many times she was not a “morning person” and did not want to have sex in the mornings. He only approached her in the mornings for sex and never at night. This type of problem does not require a sex therapist but is an ideal problem for an MFT to treat. MFTs should review the presenting sexual problems that may qualify as an Axis I dysfunction, but do produce similar levels of distress (i.e., varying levels of sexual desire or different ideas about turn-ons). Some options for diagnosis in this factor are discussed later.

In many cases, the distress is not individual or intrapychic, but interpersonal. In fact, in our experience, many couples present with sexual problems because it is the partner without the “problem” who is upset. This can occur when there are different expectations of the sexual relationship or sexual behavior, different learning histories, role changes, or others. It is incumbent upon the therapist to identify to what extent, if any, there is a discrepancy in the couple’s report regarding the problem and identify whether the distress is experienced by the individual or couple.

Comorbidity.
Frequently, sexual health concerns also co-occur with chronic illness, physical conditions, mental health problems, mood/anxiety disorders, and/or substance abuse problems. Depression can contribute to a variety of sexual problems, including hypoactive sexual desire disorder (HSD), dyspareunia, and erectile dysfunction, to name a few. Other sexual problems such as painful intercourse and erectile dysfunction may increase the likelihood of the development of HSD (Weeks, Herlekin, & Gambescia, 2008). A classic example involves a couple experiencing an erectile problem. A husband, significantly older than his wife, was taking multiple heart medications. He found that when he tried to have intercourse, he failed to obtain an erection and consequently began to avoid sexual interactions in order to avoid the feeling of failure and of disappointing his partner. His wife’s interpretation of his hesitation to engage in sexual activity, however, was that he simply lacked desire for her (not an uncommon interpretation in couples). A single therapy session cleared up this misinterpretation and initiated the process of how to have sex more effectively. In this case, the wife was convinced that his erection problem demonstrated he was losing sexual interest in her. It was critical that she be educated on the following: (1) erections and desire are not necessarily the same; (2) give her partner’s age, medical problems, medications, and rapidly increasing performance anxiety to please her, it was very likely he would demonstrate some erectile problem. The therapist worked with the man to help him understand that it was essential that he verbalize his desire for her and to take enough Viagra to overcome his medical condition. The most important element of this session, however, was that they both knew the other still felt strongly
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desire, which for them was equated with love and commitment. Men with a unique physiological composition or illnesses such as diabetes, epilepsy, and multiple sclerosis may be more vulnerable to erectile dysfunction, but negative cognitions and performance anxiety also contribute (Betchen, 2008). Patients with certain types of cancer may be more prone to sexual and desire problems for both physical reasons (e.g., damage to sexual organs) (Seagraves & Balon, 2003) or psychological reasons (e.g., body image concerns) (Waldman & Eliasof, 1997). Therefore, MFTs need to conceptualize and treat the problem within the entire client context and research how sexual problems stem from or contribute to other issues. There may be a reciprocal relationship between the level of relationship satisfaction and sexual problems. For an overview of the individual biological and psychological factors related to each sexual dysfunction, see Herdtlin et al. (2008).

Multiaxial Diagnosis from the Intersystems Perspective. In many cases, problems with one's sexual health are exacerbated by relationship difficulties, such as power imbalances, resentments, or communication concerns. With this etiology, traditional behavioral non-systemic prescriptions will not change the sexual problem. Our preference is to treat the couple problems first and then move on, or begin to phase in, the treatment of sexual problems (Guay et al., 2003). A couple locked in conflict, or one that has intimacy problems, which are expressed via sex, will fail to respond to the traditional approach of giving sensual/sexual prescriptions. Once again, the systemically-oriented therapist has the advantage over the behaviorally/ individually-oriented therapist due to the more comprehensive perspective.

In same-sex relationships, there are other considerations. In addition to the assessment of how individual, interactional, and intergenerational factors play a part in the development and maintenance of a sexual problem, MFTs should attend to the problems of heteronormativity and internalized oppression (Herdtlin et al., 2009) and recognize that heteronormativity underlies the diagnostic categories in the DSM. For example, the sexual pain disorders refer to pain during intercourse, which eliminates lesbian women who experience pain under other circumstances (Herdtlin et al., 2009). Other factors specific to same-sex relationships that need to be considered are lack of education, HIV status discrepancies, and therapists should also be aware that their knowledge and any countertransference issues about same- sex relationships can affect the treatment process (Bettinger, 2004; Nichols, 1989).

There are several authors who outline how to conduct sex therapy for same- sex couples. Reece (1988), George and Behrendt (1987), and Carballo-Díéguez and Reimen (2001) identified specific interventions for working with same- sex couples, such as therapist education and awareness of own values, addressing internalized homophobia, and specific sexual strategies. Further, Reece (1987), Hall (1987), and Beringer (2004) each developed frameworks for treating same-sex couples with sexual problems. Beringer’s approach is systemic and was developed for gay male couples. Hall’s approach is for lesbian couples and includes looking at the larger contexts in which the couple is embedded. Reece’s (1987) framework is directed toward gay couples experiencing discrepancies in sexual desire.

The Intersystems approach provides a framework for therapists to consider both the physical as well as dyadic concerns, which are impairing a couple’s sexual health. The severity of the relationship problem and the extent to which it impacts sexual health will be a critical component to the course of treatment (Herdtlin et al., 2009) and therefore should be reflected in the multiaxial diagnosis. Relational diagnostic codes most frequently used by sex therapists include Partner Relational Problem or Physical/Sexual Abuse of an Adult (V61.1), Relational Problem Related to a Mental Disorder or General Medical Condition (V61.9), or Relational Problem (V62.89).

Because “sexual health” is an all- encompassing term relating to one’s physical, social, and emotional well being, MFTs should account for each axis in their diagnosis. In order to promote sexual health, therapists should attend to all aspects which might be Working with the Chronically Ill

Therapists should be vigilant for clients who have been diagnosed with chronic illness and are experiencing sexual problems. There are several illnesses that affect sexual functioning, including (but not limited to): Parkinson’s disease (Yu, Roane, Minner, Fleming, & Rogers, 2004), Multiple Sclerosis (Smeltzer & Kelley, 1997), stroke (Montaner & Kerrigan, 1997), cancer (Waldman & Eliasof, 1997), rheumatoid arthritis (Shaver, N thesis, & Jensen, 1988), and cardiac concerns (Shaver & Jensen, 1988).

Physical consequences of illness. Physical consequences of experiencing chronic illness can include a range of sexual issues, including loss of desire, arousal problems, orgasm problems, erectile dysfunction in men (Shaver & Jensen, 1988; Tilton, 1997), and dyspareunia in women. For some illnesses such as cancer, women may experience lubrication difficulties (Shaver & Jensen, 1988) and changes in genital sensation. There may be changes in the motor system that can make sexual acts more difficult (rigidity, tremors, etc). Another issue may be the greater occurrence of genitourinary infections.

Physical consequences of pharmacotherapy treatments. While pharmacological treatments for physical and mental illnesses frequently address the disorder and reduce symptomatology, these medications may have unintended sexual side effects. Seagraves and Balon (2003) reviewed the side effects of medications, and therapists should have this book on hand as a reference guide in order to understand how medications are impacting the sexual clinical picture. Heiman and Meston (1997b) noted that there are three principal ways medications affect sexual functioning: peripherally, centrally, and hormonally. Common consequences appear to be delayed or diminished orgasm, impaired sexual desire (more common with SSRIs as opposed to MAOIs) (Heiman & Meston, 1997b). Further, some of the sexual side effects of antipsychotic medications include reduced desire and orgasm problems, though such effects could be related to the extrapyramidal side effects of antipsychotics and the likely lowered sexual functioning prior to the illness (Heiman & Meston, 1997b). Hormone therapy may also result in diminished desire and arousal for both men and women. For men, treatments for prostate cancer that involve reducing the testosterone level as low as possible frequently reduce desire and arousal. Retrograde ejaculation can be a side effect of some treatments. In cases where there is surgery because of damage to important nerves, there may be reduced sensation as well as impaired erectile ability for men and lubricating capacity for women. For women, pelvic surgery can cause scar tissue, reducing the size and shape of the vagina, and result in dyspareunia.

Psychological consequences. Psychosocial factors have been identified as contributing to sexual dysfunctions in populations discussed above with chronic illness, including relationship dissatisfaction, depression, and body image concerns (Waldman & Eliasof, 1997). After a period of suspended sexual activity, anticipatory anxiety can fuel the loss of desire, creating a self-fulfilling belief that spirals into further sexual difficulty. Pelvic or genital surgery can also have a psychological impact, in that patients may question their gender and sexual identities.

Treatment considerations. MFTs need to be vigilant about the presence of illness as a contributing factor of sexual problems for a couple by conducting a thorough history. For many clients, they need to be reassured that normal or near normal functioning will return, but they need to be patient and find other means of sexual expression until that time. For other clients who will not have the opportunity to return to normal functioning, the therapist and couple can develop alternate ways to demonstrate sexuality. This involves being creative about sexual behavior and their definition of intimacy. Further, MFTs need to be aware of the importance of collaboration between therapists and the primary care or specialist treating the patient for this concern. Many of our clients do not report their sexual health concerns to their physicians because of embarrassment or shame. Collaboration allows the most effective course of treatment to be implemented.

Figure 1

Women unable to lubricate
Men unable to keep an erection
Climax too early
Anxiety about performance
Locked interest in sex
Unable to achieve orgasm
Sex is not pleasurable
Experience pain during sex

Percentage of population

0 5 10 15 20 25 30 35

Women
Men

Figure 1 shows the frequency of sexual dysfunction in the general population in the U.S. This study is fairly consistent with other studies that have been conducted. This research team and others have demonstrated that almost every couple coming to therapy has a high probability of having a major sexual problem. Percentages are taken from individuals completing the survey in regard to their own behavior.

where a couple systematically becomes more tuned to each other’s body. Sensate focus is a behavioral intervention that was introduced by Masters and Johnson (1970) and refined by Kaplan (1974). In general, the therapist begins by working with the couple forward incrementally toward experiencing varying degrees of sexual pleasure through non-erotic or non-genital touch. Typically, couples are asked to participate in sensate focus-related homework activities three times per week, with each activity designed to be pleasurable and focus on how each partner communicates to the other. Eventually, the couple gradually moves from positive, non-genital touching experiences to intercourse. See Weeks and Gambescia (2008) for a further discussion of how to conduct systemic sensate focus work.

Biomedical Treatments. Recently, many pharmaceutical companies have worked to address the problem of sexual dysfunction through biomedical treatments. The development of Viagra® (sildenafil) in 1998 dramatically shifted the sex therapy field toward a medical intervention orientation. Since its development, other companies began to develop comparable medications to stimulate the claim on this issue, such as Levitra® (vardenafil) and Cialis® (tadalafil) (Verhulst & Reynolds, 2008). In short, there are many pharmacological options to assist men with their erectile problems, and these problems are seen as strictly medical problems that can be treated via pharmaceuticals rather than marriage and family therapy or systemic sex therapy (Ridley, 2008; Verhulst & Reynolds, 2008). Another treatment approach for men is testosterone replacement therapy, particularly if they suffer from a low level of the hormone. As a result of continued medical developments, individuals experiencing these sexual problems may pursue medical solutions rather than therapeutic approaches (Ridley, 2008; Weeks & Gambescia, 2008). However, this does not allow for an understanding of the sexual problem as something that may be caused by other problems.

Drug companies have been working to develop solutions to address the other factors affecting health, including medications that are designed to treat low desire. For women, such medications tend to focus on adjusting hormone levels, so they can help women by improving vaginal tone and elasticity, and increasing vaginal blood flow and lubrication. Progesterin therapy can increase desire and arousal when paired with estrogen therapy. Androgynic therapy provides male hormones to women. Such medical interventions can be controversial since long-term effects are unknown. Other physiological treatments for women include strengthening pelvic muscles through Kegel exercises (Herlstein et al., 2008; VandeCreek, Peterson, & Bley, 2007), consultation with a physical therapist (Meena, 2008) and herbal supplements, such as Ginkgo biloba, which can improve circulation throughout the body. However, therapists should advise clients that there can be severe risks to any supplements taken (FDA, 2006) and that many of these supplements are not approved by the FDA. Further, while there are claims that the biggest Viagra® can be effective for women, most of the research fluctuates between being biologically proven and demonstrating it is not effective. Bancroft (2002) advised that therapists exercise caution when considering the use of Viagra® for women, particularly because of the difference in sexuality between men and women and the recognition that sexuality is a complex interplay of emotions, cognitions, and other factors. PDE-5 inhibitors (like Viagra®) should not be prescribed as the solution for returning to a satisfying sex life. When the sexual problem has some of its roots in communication problems, conflict, and sexual addiction, biomedical treatments will not achieve the desired end. Additionally, medical intervention focuses on an individual rather than a couple, and treatment decisions are made by the symptomatic individual. Once erection can be achieved, it may be difficult for the couple to resume the same pattern of sexual relations, providing there were previous difficulties that may have existed previously, particularly if there was a significant amount of time where the couple was absent. MFTs are trained to consider how each system is working to contribute to the problem, and not to stick to a paradigm that encompasses the systemic conceptualization of an MFT. The Intersystems approach fills this niche. The therapist facilitates work that resolves the complex myriad of issues that have produced the problem as well as the distress that the problem has created for the relationship. The key for MFTs is to understand that medical alternatives are available, but to encourage the couple to conceptualize the case from an Intersystems perspective in order to pursue a wide range of treatments (behavioral, relational, etc.) for the greatest chance of success. MFTs should bear in mind that, while the medical solution may be a tempting one, physicians often do not have the time or training to discuss potential relationship factors that are complicating the sexual problem for partners, and this information is typically not included in the medical evaluation (Leiblum, 2007).

Systemic Treatments: The Intersystems Approach. Because the field of sex therapy has been heavily influenced by biological and psychodynamic interventions, there are few truly systemic treatments. Wincze and Carey (2001) outlined a model that integrates biological and psychological factors in sexual dysfunction; Borelli-Kerner and Bernel (1997) emphasized the importance of couple’s treatment in sexual dysfunction. As approaches fall short in consistently and completely attending to the individual, interpersonal, and sociocultural components of a client’s sexual problem, systemic therapies (behavioral, interactional, and intergenerational components of a client system. See Herlstein et al. (2008) for a detailed description of how to apply the model to the sexual dysfunctions.

Improving Sexual Health

Considering sexual health from a systemic perspective, there are several specific ways we have developed to improve sexual health for clients. The first step is to conduct an assessment addressing each of the dimensions outlined in the Intersystems approach. This includes a comprehensive sexual history attending to individual dynamics, relationship satisfaction, family-of-origin factors, and socialization factors. By conducting your assessment, attend to the physical, social, emotional, sociocultural, and intellectual factors that are contributing to the vulnerabilities in sexual health. The second step is to provide education to the clients. This can include correcting the misinformation that the couple may have, as well as providing more alternatives to sexual interaction, as a way to redefine sexual health and intimacy. Bibliotherapy and education can be very powerful adjuncts to treatment in such cases where the problem is compounded by a lack of education. Couples may hold many myths about sexuality and sexual behavior, and bibliography can be one manner of helping clients separate myth from reality. Effective bibliotherapy in sex cases can include videos, books, and use of the Internet. Specific suggestions are outlined in the Resources section of this Update as well as in Herlstein et al. (2009).

The proper maintenance of sexual health can be accomplished through the prevention and/or treatment of sexual issues. MFTs need to encourage their clients to talk about their sexual health, even if the therapist experiences discomfort doing so. Years of experience show that many couples are simply reluctant to bring up sexual problems until later in treatment, if at all. If the therapist asks general questions about sexual functioning, some couples will report that their sex life is satisfactory. At some point, after establishing a relationship, the therapist can suggest to the couple that little has been said about sex. The therapist can then ask specific questions such as: Are you two of the happy with how often sex occurs? Do you have any problems getting or keeping an erection? Are you able to delay ejaculation long enough so that you are both satisfied? (both partners)
• Are you both able to have an orgasm? Would you like anything to change around your ability to have an orgasm?
• Is there any pain with intercourse?

A series of specific questions may be asked if the therapist expects to get a clear picture. The questions above are just a sample and can be worded differently to fit each couple.

In couples with no apparent sexual health concerns, create a treatment plan that will encourage them to maintain their sexual health. Include strategies such as:

- Providing education and recommending bibliotherapy
- Addressing fears
- Starting slowly
- Monitoring progress

Therapists who are best trained to address the sexual health of a client are knowledgeable about couple therapy, sex therapy, medical sex therapy, psychology, and larger systems. Effective treatment encompasses, at a minimum, assessment in each of these areas and hopefully intervention in whatever areas difficulties exist. Because of the perception by some clients that sexual dysfunction is easily treated with medications, it is incumbent upon the therapist to explain how each of the areas may be contributing to the sexual problem, and educate the couple on treatment options for the individual, interpersonal, and intergenerational components.

Resources for Practitioners

American Association of Sexuality Educators, Counselors and Therapists (AASECT)

www.aasect.org

A resource for client referrals, ethics information, as well as job listings, and FAQs about human sexuality.


Provides a communication forum, newsletters, sex therapist directory, and links to resources.

Society for the Scientific Study of Sexuality (SSSS)

www.sسس.org

SSSS is an interdisciplinary organization that values quality research as well as educational, clinical and social application of sexuality; providing people access to various publications, as well as information about awards and grants that are available.


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References


CONSUMER UPDATE BROCHURES

Here is a sample of the Consumer Update brochure on Sexual Health. This brochure is designed to educate consumers and to market your services, with space on the back to imprint your name and contact information.

MARKETING TIPS
To market your services to individuals and families who may be faced with this issue, distribute copies of the Consumer Update brochure to:
• Physicians and nurse practitioners in family practice
• Community resource centers
• Local hospitals and urgent care facilities
• School and university counseling programs
• Churches, synagogues and temples
• Mental health agencies and health fair

HOW TO ORDER
These brochures are available for purchase in packs of 25. The cost per pack is $8.75 for members and $11.25 for non-members. Contact AAMFT Member Services by e-mail at central@aamft.org or by phone at 703-838-9808. Online order at www.aamft.org.

Consumer Update brochures are also available on the following topics:
•Adolescent & Young Adult Health
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•Financial, Legal, & Other Issues

*Consumer Update brochures are available in packages of 25. The cost per pack is $8.75 for members and $11.25 for non-members. Contact AAMFT Member Services by e-mail at central@aamft.org or by phone at 703-838-9808. Online order at www.aamft.org.

Consumers are educated about the normalcy of sexuality and many developing sexual dysfunction in Parkinson’s disease. American Journal of Geriatric Psychiatry, 12, 221-226.


