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MASTERS OF SEX: Sexuality in the Dialysis Population

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Disclosure Information

- No financial relationships to disclose

Learning objectives

1. identify the primary contributing factors to sexual dysfunction in renal patients

2. Reflect on and determine one's own personal bias and comfort level in discussing issue of sexuality and sexual dysfunction.

3. Apply effective methods of engaging in supportive conversation to assist renal patients in finding appropriate resources to address sexual dysfunction

What is sexuality?

- Spans biological, psychological, social, emotional, spiritual dimensions
- Sexuality as “beginning with the relationship they had with themselves and extending to their relationship with others. As such, it is so much more than just the biological functioning, but includes prior experiences, trauma, self image, etc.” (Kralik, et al)
- Closely linked to conceptions of “femininity” and “Masculinity”
- Taboo subject – leads to feelings of isolation and solitude

Dysfunction / Satisfaction / Activity

- Many of the studies on sexual function carefully noted the difference between these concepts.
- What is sexual dysfunction?
  - "a set of disorders characterized by physical and psychological changes that result in the inability to perform satisfactory sexual activities". (vecchio)
  - Functioning of genitalia; desire phase disorders (Mor)
- What is sexual satisfaction? (can coexist with sexual dysfunction)
- What is sexual activity? pts considered sex as less important after starting dialysis (Fryckstatdt).
- High prevalence of sexual inactivity in this population. Need to differentiate between sexual inactivity and dysfunction. (Mor et al)
- Masters and Johnson's model, published in 1969, was the widely accepted understanding for sexual response and arousal. First expanded the understanding of "sexual response" – there is no normal.Harlan's model published in 1977 has in some ways added to and changed some of the previously accepted theory.

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Masters of Sex, Season 4, Episode 5 (Showtime)

Satisfaction vs Inactivity

- FSFI: Female Sexual Function Index
- Sexual inactivity and FSFI-defined sexual dysfunction do not necessarily translate into sexual dissatisfaction among women on dialysis
- Most women on dialysis, including those who are not sexually active, are satisfied with their sexual life.
- Women reported sexual difficulty as a cause for sexual inactivity on only 2% of assessments.
- Argument against routine screening: Women on dialysis are not eager to understand the causes of the problem and pursue available tx options. (Mor, et al)

Study Limitations

- Difficult to apply findings across the overall pt population
- Almost all of the studies had imitations, such as survey size, population, geographical area, gender, modality or age groups
- Age appears to be the single most predictive factor for both ED and decreased libido in both men and women

Patient Descriptions

- Qualitative studies have power to create positive change for the participants
- The qualitative method – collect the data and see what emerges, as opposed to designing a study and testing a hypothesis or intervention. (Blackwell)
- Sharing their stories (the researcher shared excerpts with other letter writers) empowered them to make changes in their lives.(the study became an outcome)
- Experiences vary widely based on gender, age, modality, other disease/illness
- More qualitative research is needed to fully understand the concepts and further educate health care providers on the complexity and nuances of the subject matter.

Commonalities and Diversity of sexual experience

- Much of the literature surveyed made a distinction between female and male sexuality –must be studied and understood differently.
- Tended to focus on specific issues for men in the studies: ED was primary issue for men
- Tended to focus on overall sexual satisfaction for women
- Lack of desire is common complaint in physically healthy population (Dailey)
- Age and overall health status is an important determinant in both importance of sexuality, sexual satisfaction, and need for more information. (muehrer)

Direct Contributing Factors to Dysfunction

- Direct factors:
  - Changes in testosterone production, prolactin secretion, hormonal alterations, all lead to: erectile dysfunction, decreased libido, and arousal phase disorders
  - Anemia; Inadequate HD, Disruption of sexual desire and response from pain
  - Disruption of genital response from co-morbid disease (HTN, diabetes)
  - Medications: erectile dysfunction can be side effect of anti-hypertensives

Direct Contributing Factors to Dysfunction, cont

- Direct factors:
  - Vascular insufficiency, vascular calcifications, blood flow, hyperlipidemia/ atherosclerosis are contributing factors, independent of dialysis (this is why age is a factor – the older we are the more likely we are to develop this problem). (Basson, et al)
  - Age – prevalence of ED and low libido increases with age
  - Disruption of the hypothalamic-pituitary-adrenal axis (Gorsane)

Indirect contributing factors

- Indirect contributing factors:
  - Change in lifestyle that come with chronic treatment;
  - Body images changes
  - Altered self image (medicalization of bedroom)
  - Depressed mood, reduced energy, partnership difficulties,
  - Impaired mobility
  - sense of loss of sexuality from imposed infertility (Dailey)

Indirect contributing factors

- Indirect contributing factors:
  - Fear of sex, worsening condition
  - Symptom burden is extensive: from bone and joint pain, fatigue, anorexia, nausea, stomatitis, unpleasant taste, pruritus, and malnutrition (basson)
  - Limiting factors for sexual desire: fatigue, itching, cramps, restless legs, headache, smell, feeling of sickness, pain, impotence, no desire, no partner. (Fryckstedt)

Depression

- Link between depression and sexual dysfunction is established in the general population, as well as Renal population. (Peng)
- Sexual problems related to chronic illness are multi-factorial; but strongly correlated with depression
- Management of depressive disorders are necessary in order to evaluate and treat sexual dysfunction (Peng)
- Strong link between ED and later depression in men demonstrated by several studies

Peng, et al

Quality of Life

- Conflicting findings as to whether the presence of sexual dysfunction among sexually active women is associated with depression or lower QOL (mor et al).
- Patients with higher sexual desire had better social functioning in these studies.
- In female hemodialysis patients, sexual dysfunction is associated with lower physical functioning and mental health (Peng)
- Any physical or psychological disorders that could affect one's quality of life also affected sexual desire and function. On the other hand, because the inability to have normal sexual life can erode an individual's sense of self esteem and lead to emotional and marital tension, quality of life is diminished in patients (Read this again)
- True for both male and female pts (peng)

Age and atherosclerosis

- Hypertriglyceridemia (history of cardiovascular disease) was strongly associated with dysfunction in the dimensions of quality, desire, lubrication, orgasms, and clitoral sensation (Peng, et al)
- Hypertriglyceridemia was associated with lower total IFSF (index of female sexual function) scores.
- "Uremic patients with increased serum triglycerides have usually had more advanced atherosclerosis. This implicates vascular insufficiency as the major cause of sexual dysfunction in our hypertriglycemic patients" (peng, et al)
- The association of increasing age and sexual dysfunction has been previously demonstrated in non-uremic subjects.

Areas of concern for patients: Bias and Comfort

- Three themes in the Blackwell study: The changing body, managing the needs of others, and communicating sexuality.
- We must understand the difficulties and concerns patients have about sexuality/sexual function, in order to guide assessment and intervention. (Muehrer)
- Gap in the literature: Done little to help clinicians understand the specific sexual concerns of pts.
  - 69% of respondents reported being concerned that their MD/RN were not open to talking about sexual concerns.
  - 81% were concerned that their MD/RN did not think sexuality was important. (Muehrer)

- Help our patients re-define the concept of “sexual function” and healthy “sexuality” to create a definition that is flexible, broad, and likely to lead to successful “practices”
- Educate our staff about sexuality – to help us all understand the various components of sexuality and what the barriers are for our patients
- Create space and safety to initiate these conversations
- Reflect on our own knowledge and comfort level and fill in the gaps.
- Normalize the discussion

Role definition within the Renal IDT

- A symptom management strategy (in which a team of nurses made recommendations to pts/nephrologists) did not result in clinically significant improvements in their symptoms of pain, ED and depression. (weisbord)
- Obstacles: (1) renal providers may be disinclined to prescribe to treat the issue – they refer to PCP. 65-80% of pts do not have a PCP. (2) financial/insurance related barriers to providing treatment.
- Establishing the safety and efficacy of tx for these symptoms does not necessarily translate into their routine implementation and effectiveness in the clinical setting.

Role definition within the Renal IDT

- Not all symptomatic pts were willing to accept tx recommendations, or considered their symptoms too mild to warrant aggressive treatment
- Pts may have felt uncomfortable agreeing to therapy recommended by research nurses that were not members of their dialysis team. (
- Providers may have been unfamiliar with or had concern for adverse effects of pharmacologic tx (Weisbord, et al)

Weisbord, et al

Medical Treatments:

- PDE5 inhibitors: Sildenafil (Viagra) and Tadalafil (Cialisis, Adcirca) Vardenafil (Levitra). Originally developed to treat pulmonary arterial hypertension. Oral pill form. Vasodilator: widens blood vessels and improves flow of blood.
- PGE1 (Prostaglandin: Alprostadil. Benefits those nonresponsive to PDE5. Injectable form. Common brands: Prostin VR, Caverject Impulse, Muse.
- There are no easily administered and effective tx interventions for most forms of female sexual dysfunction in dialysis patients (mor) (talk therapy, supportive counseling)

Treatments

- Phosphodiesterase -5 inhibitors (PDE5i), intracavernosal injections, intraurethral suppositories, hormonal therapy, mechanical devices, and psychotherapy.
- The effectiveness and safety of these interventions has not yet been studied thoroughly (Vecchio, et al)
- Sildenafil to female HD pts who developed sexual dysfunction after taking serotonin reuptake inhibitors demonstrated improvement in sexual function (Seethala, et al)

Some takeaways:

- Treat the underlying causes (hyperlipidemia, depression, cardiovascular diseases)
- In particular, control triglycerides
- Treat the indirect and direct contributing factors: Some of these factors can be addressed by optimizing the treatment: longer and more frequent dialysis; EPO or Vit D, (Fryckstedt)
- Adequate HD both prevents ED and improves it –but research with female pts does not support this conclusion (Peng)
- Pts cite side effects of dialysis as the limiting factors for desire. Can we be more precise in our education? Target what really concerns them?
- Oral zinc? Not yet fully studied.

Non-medical treatments

- Treat Depression
- Address and change attitudes and expectations of what sexuality looks like for chronically ill patients.
- Address overall Quality of Life issues
- Psychological approaches:
  - Begin with removing performance anxiety
  - Providing sexual tasks that can't fail – redefining sexuality to encompass other aspects than just coitus. The focus is pleasure, not genitalia
  - Establish communication between partners

Importance of engaging in supportive conversation

Identified areas of sexual concern by patients:

- Health consequences of having sex,
- Partner related concerns,
- Concerns about a lack of treatment for sexuality problems
- Concern about communication with healthcare providers about sexuality. (Tunckiran)

2 studies stressed the importance of involving partners in the discussion:

- The partners satisfaction is integral to the pts satisfaction. (Tunckiran)
- Importance of *encouraging* patients and their partners to discuss sexual concerns with each other. (Muehrer)

Supportive conversation

- Most important: Listen with empathy. Provide a safe space. If it isn't safe, explain and refer. (give options for staff: refer if not comfortable)
- Free ourselves from rigid notions of what is normal and appropriate sexuality (Golden)
- Provide tools to encourage partners to talk to each other – example: John Gottman "salsa deck"
- Simple interventions – handing out a brochure normalizes the concern and encourages asking for more information or help. How many clinics do that?

- Build trusting relationship with pt, provide quiet and private area (not CHT's domain)
- Assess pts concerns/fears by initiating dialogue
- Offer support by attentively listening in a relaxed and non-judgmental manner
- Show respect for pts sexual values and beliefs, but provide space to re-define or broaden them
- Educate pts and refer to therapist/social worker/group therapy (Tanyi)

Supportive conversation

- Our patients want to talk to us – we are a part of their trusted treatment team, so we need to be comfortable and knowledgeable.
- Normalize that there is no "normal" – sexual experience is truly subjective. (Masters of Sex)
- Build trust with pts by providing confidentiality – no joking, taking loudly about pts to others, etc.
- Offer support by listening attentively and non-judgmentally
- Show respect for pts values and beliefs

Supportive conversation

- Involve dialysis nurses who are part of the patient's treatment team in the management of symptoms - may make therapeutic interventions more acceptable to patients. (Weisbord)
- They trust us – can we hold space for their stories? (Blackwell)
- Sharing stories allowed them to learn from one another, not simply to have a disease treated by their MD with medicine. The assessment/story telling was the intervention. (Blackwell)

PLISSIT Model (Katz)

- Permission
- Limited Information
- Specific Suggestion
- Intensive Therapy

BETTER model (Katz)

- Bringing up the topic
- Explaining that sex is a vital part of life
- Telling patients that resources can be found to address their concerns
- Timing of the intervention can be adjusted to the pts need
- Educating patients on sexual effects of tx
- Recording

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Questions

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