Fatigue, muscle spasms, bladder/bowel dysfunction, pain and discomfort are all factors which adversely affect sexual activity: from arousal through to achieving an orgasm.

Early morning sex may help to avoid the effects of fatigue.

In MS, the commonest problem is fatigue, whereas in arachnoiditis, one might expect pain and difficulty in using certain positions to be the main source of problems.

Relief from muscle spasms may be achieved by using antispasmodic medication such as baclofen, an hour prior to commencing sexual activity.

Fear of loss of bladder/bowel control during intercourse may strongly discourage sexual activity. Firstly, a frank discussion with the partner should help to reduce the fear.

Strategies such as emptying the bladder prior to sexual activity can be helpful.

Loss of concentration (often due to medication) may mean that one's attention wanders, which can be interpreted by the partner as loss of interest or an implied criticism of their technique. Again, this needs to be discussed openly.

The main strategy should be to minimise non-sexual or romantic stimuli and maximise sensual and sexual stimuli; this can be achieved in a variety of ways which helps to provide ?multisensory stimuli', thereby reducing ?cognitive drift.'

In arachnoiditis, there may be allodynia (pain from non-painful stimuli) in large areas of the body. Light touch may be particularly troublesome, as may change in temperature.

Ensuring a warm, draught-free room addresses the latter problem and developing awareness of the ?OK' areas and the ?No go' areas will help to map out the best and worst parts of the body as regards sensual stimulation.

Sometimes touching the edges of numb areas can be erotic, but in other individuals, it may trigger burning pain which persists after the stimulation has ceased.

It may be that stimulation of non-genital areas will reduce the effectiveness of genital stimulation.

If this is the case, adopting positions which minimise touch in non-sexual areas of the body can help with focussing the attention solely on the sensory messages from the genitals.

The ability to ?block out' pain sensation may be required before appreciation of other sensations can be established.

There are a variety of cognitive therapy methods which may allow a reduction in the impact of pain sensation, in particular the emotional component, the reaction to the pain: upset, fear, anger etc.

If someone becomes accustomed to ?ignoring' his/her constant pain, he/she may also have learnt to ?shut out' all sorts of bodily sensations.

It may then be necessary to learn how to focus on sexual sensations whilst ignoring pain sensation.

Once sexual arousal is underway, there may well be a significant decrease in the perception of pain: the sexual sensations effectively distracting the attention.

It is important for pain sufferers to be aware of this, as they may otherwise believe that the pain cannot be overcome in this manner.

It means that sometimes by persevering despite an apparent lack of desire can result in more than satisfactory results not only for the healthy partner, but also for the ill one.

There is evidence that sexual arousal confers a reduced perception of pain, i.e. the pain threshold is raised.

Concern about hurting the ill partner can lead to the healthy partner losing libido.

Working together to establish which positions for intercourse cause minimal discomfort will enable a return to an enjoyable sex life for both partners.